MANITOBA PUBLIC INSURANCE

THERAPY DISCHARGE REPORT

Claim #:

Surname of Patient: | Given Name: | Current Age: | Date of this Examination: YYYY MM DD

Symptoms: Is the patient improving? ☐ Yes ☐ No
List all the symptoms that remain as a result of the collision:

Objective Signs:

Neurologic Examination: ☐ Normal. If abnormal, please list deficits below:

☐ Cognitive Deficit — Describe

☐ Sensory Deficit — Cutaneous Territory

☐ Motor Deficit — Muscles Affected

☐ Reflex Changes — Levels Affected

Self-Assessment Tool: (Check and score all that apply/min of 2)

☐ 1. Numeric Pain Rating Scale (NPRS)
☐ 2. Roland Morris Back Pain Questionnaire
☐ 3. Neck Disability Index
☐ 4. Yellow flags Questionnaire
☐ 5. Lower Extremity Activity Profile (LEFS)
☐ 6. Disabilities of the Arm, Shoulder and Hand (DASH)
☐ 7. Health Status Disability (SF-12)

Clinical Diagnoses:

Injury Category: _____

Does this condition pose a safety risk to operating a motor vehicle? ☐ Yes ☐ No

Work Status: Is patient currently at work? ☐ Yes ☐ No Occupation:

If no, indicate targeted return date to regular duties YYYY MM DD

When can patient begin modified duties? YYYY MM DD

Will a return to the workplace adversely affect the natural history of the clinical condition? ☐ Yes ☐ No

Yes	No	Does the patient's clinical condition:
☐	☐	a) Preclude travel to and from the workplace?
☐	☐	b) Result in an inability to perform required tasks?
☐	☐	c) Pose a safety/health risk to the patient or their co-workers?

Explain any "yes" answers:

Discharge Plan:

Total number of treatment sessions at time of discharge:

2. Status at Discharge:
- ☐ a) Condition resolved
- ☐ b) Condition much improved
- ☐ c) Condition slightly improved
- ☐ d) Condition unchanged
- ☐ e) Condition worse

3. Reason for Discharge:
- ☐ a) Resolution of condition
- ☐ b) Insufficient improvement with tx
- ☐ c) Reach maximum # of allotted sessions
- ☐ d) Patient initiated
- ☐ e) Referred to another healthcare practitioner

4. Treatment provided:
- ☐ a) Exercise instruction:
- ☐ b) Education:
- ☐ c) Manual Therapy:
- ☐ d) Modalities:
- ☐ e) Other:

Identity of Practitioner:

Surname: | Given Name: | Practice PT ☐ AT ☐ | Manitoba Public Insurance Registered Acct #

Address (Number, Street, Apt. No.)

City | Prov | Postal Code | Tel. No. (Area Code) | Fax #

Though this report is essential, the patient must file a claim with the Manitoba Public Insurance Corporation before a compensation file can be opened.

Signature of Practitioner

Date: YYYY MM DD

Authorization of Patient or Guardian:
I hereby authorize the release of this report to the Manitoba Public Insurance Corporation in support of my claim.

Signature - Patient or Guardian

Date: YYYY MM DD

If you wish to discuss this patient with a member of Health Care Services, please phone 204-985-8770 Ext 7395