



Workers' Compensation Board  
Commission des accidents du travail

### Physical Rehabilitation Discharge Report

Please use an "X" to mark all individual boxes.

Client's Surname <b>Taylor</b>		Given Name <b>Paul</b>		Client No. [REDACTED]	Client's Gender <input type="checkbox"/> female <input checked="" type="checkbox"/> male
Client's Address <b>1236 Wiltshire Lane Miss. Jnt. LSC 4C5</b>				Area Code <b>905</b>	Telephone No. [REDACTED]
Employer's Name <b>Action Force</b>		Address <b>1790 Albion Rd. #201 Rexdale ON M9V 4J8</b>		Area Code <b>416</b>	Telephone No. <b>748-1667</b>
Referral Source Name <b>Scots</b>		Address <b>205-2300 Exlinbn Ave. W Miss.</b>		Area Code <b>905</b>	Telephone No. <b>800-8144</b>
Recurrence of Previous Compensable Injury <input checked="" type="checkbox"/> GP <input type="checkbox"/> SP <input type="checkbox"/> DC <input type="checkbox"/> WCB		Date of Birth <b>03/04/66</b>	Date of Inception <b>06/03/97</b>	Date Service Started <b>07/15/97</b>	Date of Discharge <b>05/04/97</b>
Date Form Prepared <b>05/04/97</b>		WCB Diagnostic Codes 1. <b>01000</b> 2. [ ] 3. [ ] 4. [ ]			

Use WCB Code Book to Complete Diagnostic Codes.

Injury Related Physical Problems Identified	Treatment Given Per Problem	Treatment Outcomes	
		Resolved	Unresolved
1. limited lumbar + thoracic mobility	stretching/mobilizations	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Poor trunk strength.	conditioning	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Tender mid back.	modalities	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.		<input type="checkbox"/>	<input type="checkbox"/>

**Case Summary and Clinical Opinion**

Paul improved steadily with treatment, and continued with therapy until he was able to meet his regular work demands. Paul missed appointments for the end of April 1997, but at last assessment he was able to max. lift 60 lbs, and at this point in time should be capable of meeting his regular job demands.

**Recommendations**

return to unrestricted activity     return to activity with restrictions     recommend evaluation at Regional Evaluation Centre

**Recommendations For Future Management of Restrictions**

Restriction	Probable Duration	Recommendation

Day(s) in Programme #1 <b>0</b> #2 <b>1</b> #3 <b>0</b>	Days Absent <b>11</b>	Seen by Clinic Consultant <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Condition's Report Attached <input type="checkbox"/> yes <input checked="" type="checkbox"/> no
Treatment Provided By (Print name) <b>Shirley Weinger</b>		Signature <i>[Signature]</i>	
Clinic Name <b>Physiotherapy Inc</b>	PT <input checked="" type="checkbox"/> DC <input type="checkbox"/>	Town or City <b>Mississauga</b>	Agency No. <b>001-71311-84</b>

White - Treating Practitioner    Canary - WCB Data Entry    Pink - WCB Claim File    Goldenrod - Clinic