



PHYSICAL THERAPY / OCCUPATIONAL THERAPY PROGRESS REPORT TO CLAIM MANAGERS

Worker's Name _____ Claim # _____
 Diagnosis _____ Report for dates of service _____ to _____

Total number of visits (to date for this condition): _____ Cancellations _____ No-Shows _____
Referring Physician _____ **Date of latest referral on file** _____

1. List the **objective** findings based on standard tests and measurements as well as **functional deficits** identified during: 1) the initial evaluation, 2) the last progress report, 3) the current status evaluation. Measurable goals should include a timeframe. Examples of baseline data include ROM, strength, endurance, functional (work-related) tasks or activities, soft tissue status, etc.

Baseline Measures Most Critical to Recovery	Last Progress Report Date:	Current Status Date:	Measurable Goal (Objective, Measurable, Timeframe)
<i>(example)</i> Lifting: knee to chest level 10 lbs x 1 rep	20 lbs x 5 reps	30 lbs x 5 reps	30 lbs x 10 reps by February 1, 2006

2. Return to Work:

What is your current professional estimate of the worker's potential to physically perform the job of injury?
 Very Likely Somewhat Likely Not Likely

Describe any barriers to recovery that you have identified:

If the worker will not be returning to job of injury, has an alternative job goal been identified by the worker?
 YES NO Don't know If YES, what is the goal? _____
 N/A (worker planning to return to job of injury)

Do you have a copy of the physical demands of this worker's job (of injury or new goal) for reference? YES NO

3. Status of care

To date, is the worker actively engaged in the Plan of Care? YES NO (Please explain, e.g., understands home exercise program, consistent attendance, participation in clinical program).

Is the worker continuing to make meaningful, functional progress according to your clinical plan of care? YES NO

Please describe your treatment plan and goals for the next set of treatments, including frequency and duration:

Estimated date that worker will be discharged from therapy: _____

4. Comments

5. Signature of Therapist: _____ Date: _____

Clinic: _____ City: _____ Phone: _____

Instructions for Completing this Form

Purpose: Labor and Industries (L&I) claim managers are responsible for supporting and managing all aspects of an injured worker's claim. The information in this report will clearly identify the clinical goals and return to work objectives. Use of the form is NOT required, but inclusion of all the elements in your progress reports will simplify review/authorization processes.

Please use black ink and type or print legibly. Do not disrupt your current plan of care unless you have specifically been advised that continued treatment is not authorized. The claim manager may contact you directly if there are additional questions about this injured worker's care.

Identifying Information:

- **Diagnosis:** Indicate the accepted condition(s) being treated within the therapy plan of care.
- **Report for dates of service:** Indicate the start and end date for services covered in this report. The start date would typically be the date of the last report.
- **Number of Visits:** Count visits from initial evaluation through the most recent visit including pre/post surgical care for this condition. Indicate the number of cancellations and/or no-shows.
- **Date of latest referral:** Date of your most current referral or consultation with the attending physician (AP). *Note: the AP may be deferring to a specialist for therapy instructions, but it is your responsibility to be sure the orders for therapy are from the AP.*

1. **Measures most critical to recovery:** List the physical limitations and the parameters you are using to measure progress, including functional limitations. Document baseline and interim measurements. Goals must include objective, measurable parameters and an estimated timeframe. When there are more measures than there is space available, please list the measures that are most relevant to the documentation of functional progress and/or job demands.
2. **Return to work:** It is important that both you and the worker are anticipating that the end result of therapy is a return to work. Providing concise information based on clinical observation and physical demands of the job goal will help the claim manager address this important issue. If needed, contact the claim manager to see if a job analysis is available.
3. **Status of Care:** Use this section to help the claim manager understand how involved the worker is in the recovery process and your professional opinion about the worker's progress. Include issues such as attendance, home exercise program, participation in clinical program, etc. Briefly describe your treatment plan (including frequency and duration) and any changes in goals for the next set of treatments. Clearly indicate when you estimate that therapy will be concluded.
4. **Comments:** Elaborate on any part of the care that needs explanation.
5. **Signature:** The legible signature of the therapist responsible for the plan of care, the name and phone number of the clinic in which services are provided (including the city if part of a larger group of clinics), and the date the report was completed.

This report can be mailed to the department (Dept. Labor and Industries, PO Box 44291, Olympia, WA, 98504-4291), or it may be faxed to any of the following numbers:

360-902-4566	360-902-4567	360-902-5230	360-902-6460
360-902-4292	360-902-4565	360-902-6252	360-902-6100