Claim number: ----------

Physiotherapy Rehabilitation progress report
Compensation for Occupational injuries and disease act, 1993
(Act No.130 0f 1993)

PART 1 - INITIAL EVALUATION AND PLAN

Submit with first account

Names and Surname of Employee _____
Identity Number _____Address_____
_____
_____Postal Code_____

Name of Employer_____
Address_____
_____
_____Postal Code _____
Date of Accident _____ Date of referral_____
Name of referring medical practitioner_____

Name of Physiotherapist_____
Practice Number_____
Physiotherapy Account number_____

1. Date of first treatment_____
2. Initial clinical presentation _____
_____
_____
3. Describe patient's symptoms and functional status_____
_____
_____
_____
4. Are there any complicating factors that may prolong rehab or delay recovery (specify)?
_____
_____
_____
5. Overall goal of treatment_____
_____
_____
6. Treatment Plan for proposed treatment session _____
_____
_____

Signature of Physiotherapist_____Date_____

Claim number_____

Physiotherapy Rehabilitation progress report
Compensation for Occupational injuries and disease act, 1993
(Act No.130 0f 1993)

PART 2 - TREATMENT AND PROGRESS (Monthly)

Submit on a monthly basis attached to the submitted accounts

Names and Surname of Employee _____
Identity Number _____Address_____
_____
_____Postal Code_____

Name of Employer_____
Address_____
_____
_____Postal Code _____
Date of Accident _____ Date of referral_____
Name of referring medical practitioner_____

Name of Physiotherapist_____
Practice Number_____
Physiotherapy Account number_____

1. Number of Sessions (dates) already delivered? _____From_____To_____
2. Progress achieved_____
_____
_____
_____
3. Did the patient undergo surgical procedures during this treatment period? _____
Dates of surgical procedures_____
_____

4. Number of sessions (dates) still required_____
5. Treatment plan for proposed treatment sessions_____
_____
_____
_____

Signature of Physiotherapist_____Date_____

Claim number_____

Physiotherapy Rehabilitation progress report
Compensation for Occupational injuries and disease act, 1993
(Act No.130 0f 1993)

PART 3 - FINAL PROGRESS REPORT

Submit with final account

Names and Surname of Employee _____
Identity Number _____Address_____
_____
_____Postal Code_____

Name of Employer_____
Address_____
_____
_____Postal Code _____
Date of Accident _____ Date of referral_____
Name of referring medical practitioner_____

Name of Physiotherapist_____
Practice Number_____
Physiotherapy Account numbers_____

Date of final treatment_____ Number of treatment Dates_____

Progress achieved_____
_____
From what date has the employee been fit for his/her normal work? _____
_____
Is the employee fully rehabilitated/has the employee obtained the highest level of function?
_____
If not, describe in detail any present permanent anatomical defect and/or impairment of function as a result of the accident (R.O.M., if applicable, must be indicated in degrees at each specific joint) _____
_____
_____

_____

Signature of the Physiotherapist_____Date_____