Washington State Department of Labor & Industries

Fax (360) 902-4567

Physical Medicine Progress Report

Physical/Occupational Therapist completes monthly or up to 12th visit, whichever comes first. Recommended to submit to the AP prior to their next visit.

Today's Date: _____ Type of Service ☐ PT ☐ OT

Name of Therapist: _____ Name of Attending Provider (AP): _____

Section 1: Background

Patient Name	Date of Birth	Claim Number

Diagnosis

Date of Injury	Date of Surgery	Date of Initial Eval	Total Visits Since Evaluation ____	Number of Cancellations ____
			Estimated Total Claim Visits ____	Number of No-Shows ____

Section 2: Progress Complete when the patient is present

a. Current work/job status: Next AP Appointment Date: _____

☐ Full-duty ☐ Modified/light-duty ☐ Not working ☐ No job to return to ☐ Other _____

b. Patient's job of injury: _____

c. What progress on activities/tolerances has the patient made since your last report?

d. What progress on activities/tolerances does the patient need for work and daily life?

e. **Ask the patient**: What are your expectations and/or concerns with your progress? Include RTW if applicable.

f. **Ask the patient:** In the last month, how much has your pain interfered with your daily activities?

No Interference **Unable to carry on activities**

0	1	2	3	4	5	6	7	8	9	10

g. Describe the change in frequency and intensity of symptoms:

Section 3: Current Estimated Abilities

a. List up to four essential job tasks demonstrated

Patient CAN: Examples: Bend or Lift	# of lbs as appropriate	How Often **N, S, O, F, C** *See Definitions	**Progress Towards Expected Outcome**			
			Goal Met	Improved	No Change	Worse
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

*Definitions: **N**ever **S**eldom(1-10%, 0-1 hour) **O**ccasional(11-33%, 1-3 hours) **F**requent(34-66%, 3-6 hours) **C**onstant(67-100%, Not restricted)

b. Demonstrated Objective Measurements

Muscle Strength or AROM	Current Status	**Progress Towards Expected Outcome**			
		Goal Met	Improved	No Change	Worse
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Patient Name	Claim Number

c. Self-Reported Functional Outcome Measures Refer to Documenting Functional Improvement Resource

Example: Oswestry Disability Index (ODI)	Current Score/Status	Progress Towards Expected Outcome			
		Goal Met	Improved	No Change	Worse
		☐	☐	☐	☐

Section 3 Comments

Section 4: Barriers and Strategies for Recovery

(Issues that may cause a longer-than-expected recovery time)

a. Barriers: ☐ None (skip to section 5)

Recent Injuries/Complications/Comorbidities/ Factors Impeding Recovery:
(e.g. engagement, fear of worsening, worker expectations, employment concerns, lack of support system, pain.)

☐ Difficulty adhering to home exercise program

b. What is your in-office plan for addressing any barriers identified?
(e.g. job simulation, patient education, promote independence, focus on progress, other)

c. Do you plan to contact others?: Check all that apply

☐ Attending Provider ☐ Claim Manager ☐ Employer ☐ Behavioral Health Provider
☐ Vocational Provider ☐ Activity Coach ☐ Surgeon ☐ Heath Services Coordinator

d. Services for AP to consider to address barriers:
(e.g. behavioral health, vocational assistance/job description/job modification, activity coaching, other)

Section 5: Treatment Plan & Signature

☐ Continue therapy _____ times/week for _____ wks ☐ Discontinue PT/OT because: _____

What is the patient's current rehabilitation potential? ☐ Good ☐ Fair ☐ Poor

Therapy plan of care and goals are based on:

☐ Formal Job Analysis (JA) ☐ Employer Job Description ☐ Patient described work duties ☐ Other _____

Summary/Comments on Plan:

Therapist Name/Clinic Name	Clinic Phone Number	Clinic Fax Number
Therapist's Signature	Date Signed	L&I Provider Number

Instructions for Physical/Occupational Therapist:

1.) Send your signed completed form to AP **2.)** Fax a copy to L&I at (360) 902-4567 **3.)** PT/OT ADMIN: Send final signed copy to L&I

Attending Provider Section:

Attending Provider's Response: I have reviewed the information contained in this report and:

☐ Agree with the recommendations. Will update the Activity Prescription Form if abilities or treatment plan has changed.
☐ No further treatment needed.
☐ Have changes to plan of care.

Comments/Changes:

☐ APF Attached?

Attending Provider Name	Provider Phone Number	Provider Fax Number
Attending Provider Signature		Date signed

Instructions for the Attending Provider: Send a signed copy back to PT/OT Clinic