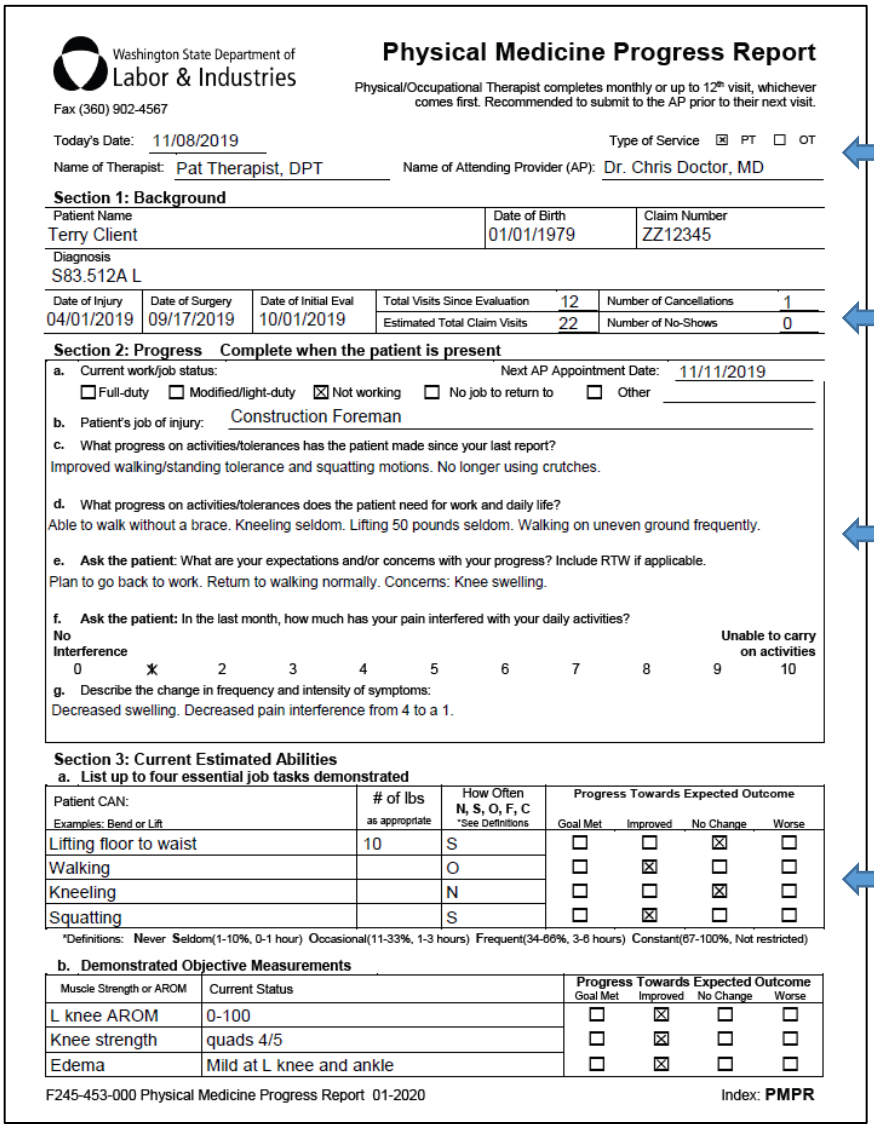
Washington State Department of Labor & Industries

Completing the Physical Medicine Progress Report (F245-453-000)

- The purpose of this form is to communicate your patient's progress with the AP, Labor and Industries, and others as appropriate. When signed by the referring provider, it lets everyone know they are aware of the individual's progress.
- Use when treating patients covered under Washington State's workers' compensation.
- The PMPR is not required for: Home health, inpatient rehabilitation, out-of-state providers, consulting therapists, or work hardening programs. In addition, the form is not required for a standard outpatient therapy initial evaluation.
- The treating PT or OT completes this form prior to the patient's attending provider (AP) visit. At a minimum, progress reports must be monthly or every 12th visit with the patient.



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: 11/08/2019 Type of Service ☒ PT ☐ OT

Name of Therapist: Pat Therapist, DPT Name of Attending Provider (AP): Dr. Chris Doctor, MD

Section 1: Background

Patient Name	Date of Birth	Claim Number
Terry Client	01/01/1979	ZZ12345

Diagnosis: S83.512A L

Date of Injury	Date of Surgery	Date of Initial Eval	Total Visits Since Evaluation	12	Number of Cancellations	1
04/01/2019	09/17/2019	10/01/2019	Estimated Total Claim Visits	22	Number of No-Shows	0

Section 2: Progress Complete when the patient is present

a. Current work/job status: Next AP Appointment Date: 11/11/2019
☐ Full-duty ☐ Modified/light-duty ☒ Not working ☐ No job to return to ☐ Other

b. Patient's job of injury: Construction Foreman

c. What progress on activities/tolerances has the patient made since your last report?
Improved walking/standing tolerance and squatting motions. No longer using crutches.

d. What progress on activities/tolerances does the patient need for work and daily life?
Able to walk without a brace. Kneeling seldom. Lifting 50 pounds seldom. Walking on uneven ground frequently.

e. **Ask the patient:** What are your expectations and/or concerns with your progress? Include RTW if applicable.
Plan to go back to work. Return to walking normally. Concerns: Knee swelling.

f. **Ask the patient:** In the last month, how much has your pain interfered with your daily activities?
No Interference 0 ✱ 2 3 4 5 6 7 8 9 10 Unable to carry on activities

g. Describe the change in frequency and intensity of symptoms:
Decreased swelling. Decreased pain interference from 4 to a 1.

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
Lifting floor to waist	10	S	☐	☐	☒	☐
Walking		O	☐	☒	☐	☐
Kneeling		N	☐	☐	☒	☐
Squatting		S	☐	☒	☐	☐

*Definitions: Never Seldom(1-10%, 0-1 hour) Occasional(11-33%, 1-3 hours) Frequent(34-66%, 3-6 hours) Constant(67-100%, Not restricted)

b. Demonstrated Objective Measurements

Muscle Strength or AROM	Current Status	Progress Towards Expected Outcome: Goal Met	Improved	No Change	Worse
L knee AROM	0-100	☐	☒	☐	☐
Knee strength	quads 4/5	☐	☒	☐	☐
Edema	Mild at L knee and ankle	☐	☒	☐	☐

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1 Enter only one type of service per form – PT or OT.
Use the date format MM/DD/YYYY.

2 If unsure, enter UNK (unknown). If it does not apply, enter NA. If no missed visits, enter zero (0).

3 When feasible, complete Section 2 with your patient present.
- c, d, g – Therapist's impression of progress and needs.
- e, f – Patient response.

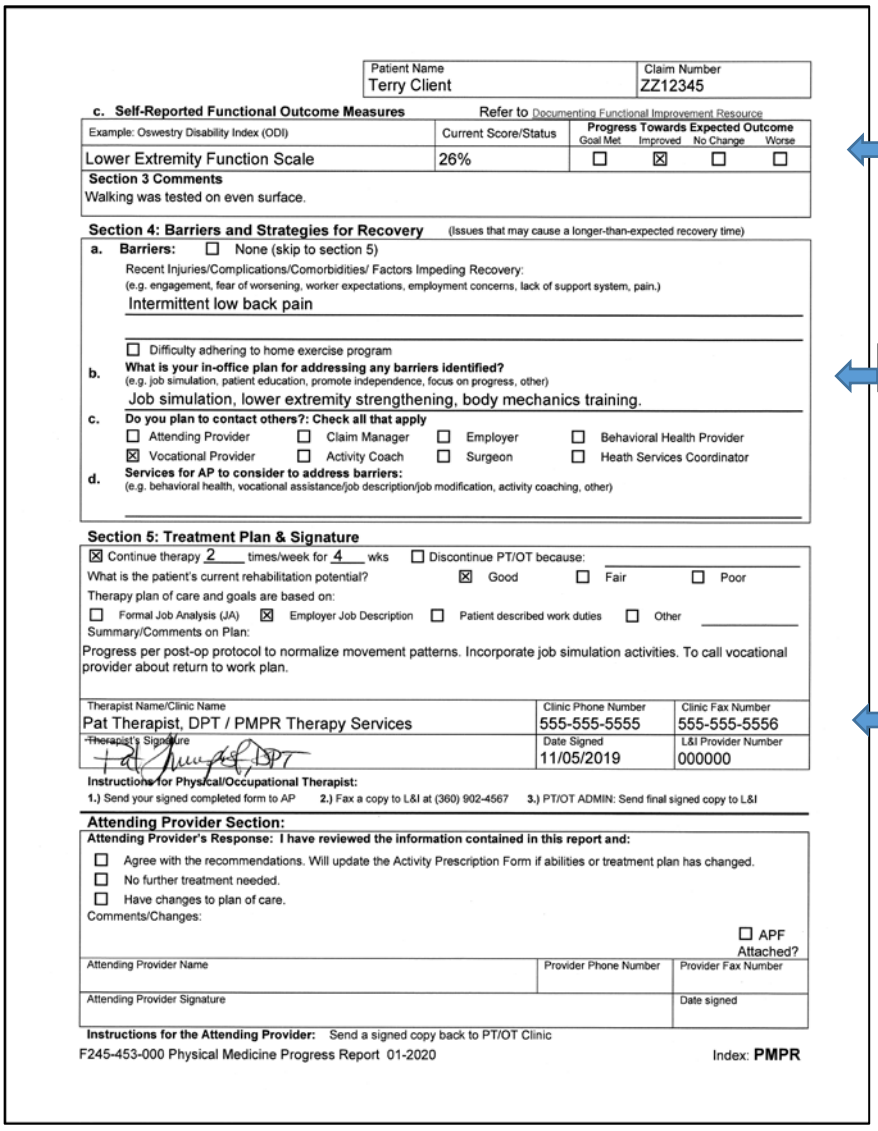
4 Your treatment goals are reflected in Section 3

If your patient is not released to perform any functional activities, skip Section 3a.

How often is an estimate based on your clinical judgement.

Never	Unable to perform
Seldom	1-10%, 0-1 hour
Occasional	11-33%, 1-3 hours
Frequent	34% - 66%, 3-6 hours
Constant	67-100%, Not Restricted

Time is based on full time 8-hour day.



Patient Name: Terry Client | Claim Number: ZZ12345

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
Lower Extremity Function Scale	26%	☐	☒	☐	☐

Section 3 Comments
Walking was tested on even surface.

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.)
Intermittent low back 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)
Job simulation, lower extremity strengthening, body mechanics training.

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 2 times/week for 4 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:
Progress per post-op protocol to normalize movement patterns. Incorporate job simulation activities. To call vocational provider about return to work plan.

Therapist Name/Clinic Name	Clinic Phone Number	Clinic Fax Number
Pat Therapist, DPT / PMPR Therapy Services	555-555-5555	555-555-5556
Therapist's Signature: Pat Therapist, DPT	Date Signed: 11/05/2019	L&I Provider Number: 000000

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

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For any comments on Section 3 a, b and c, use the Section 3 comments box

For a list of possible functional outcome measures, see L&I's Options for Documenting Functional Improvement Resource.

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Section 4: If no barriers are identified, check None. If barriers are identified, list them in Section 4a.

- If patient is having difficulty adhering to a home exercise program, check box.
- Enter your plan for addressing these barriers by listing methods in Section b, c, and d.

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Send signed copy to the attending provider.

Fax a copy to L&I at 360-902-4567.

How to find your L&I provider number? You may send an email to PHL@lni.wa.gov or PACMail@LNI.WA.GOV.