

**Innovate Treatment Services**

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**Regent House**

**Stockport, SK4 1BS**

**Telephone Assessment Report**

**Patient name:**

**Date of birth:**

**Practitioner name:**

**Date of accident:**

**Date of first attempted call:**

**Date of triage assessment:**

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| **Patient Consent** | |
| **Has the patient given verbal consent for this assessment report to be passed to their solicitor, the treating physiotherapist and the funding party?** | Yes  No |

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| **Injury and symptoms details** | |
| **Please give a brief description of the cause of the injury.** | |
| **Symptom Description** | **Pain score (please give a score out of 10)** |
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| **Factors affecting treatment** | |
| **Please give a brief description of any pre-existing conditions which may affect the patient’s recovery, including any medication currently prescribed.** | |
| **Does the patient demonstrate any yellow flags?** | Yes  No |
| **Does the patient demonstrate any red flags?** | Yes  No |
| **Is the patient currently undergoing treatment?** | Yes  No |
| **If yes to any of the above, please give detail.** | |

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| **Impact on Lifestyle** | | |
| **Household tasks** | None  Mild  Moderate  Severe  Not applicable | **Comments:** |
| **Recreational activities** | None  Mild  Moderate  Severe  Not applicable | **Comments:** |
| **Travel** | None  Mild  Moderate  Severe  Not applicable | **Comments:** |
| **Sleep** | None  Mild  Moderate  Severe  Not applicable | **Comments:** |

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| **Impact on Work** | |
| **Patient’s occupation:** |  |
| **Has the patient had any time off work?** | Yes  No |
| **If so, how many weeks have they been absent?** |  |
| **Has the patient returned to work?** | Yes  No |
| **Please rate the impact of the symptoms on the patient’s work** | None  Mild  Moderate  Severe  Not applicable |

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| **Recommendation** | |
| **Which Treatment Pathway do you recommend?** | Clinic-based physiotherapy  Further investigation required  No further treatment required  Refer for Case Management |

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| **Additional information** |
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