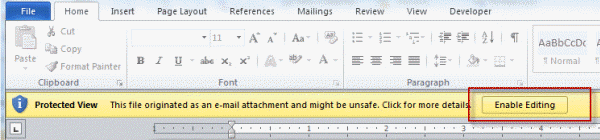
When you first open the file you may have to enable or disable security alerts on the Message Bar. If the yellow Message Bar appears click Enable to make it a trusted document. If the red Message Bar appears click the warning text. In the view that you see click the File tab, and then click Edit Anyway.



At the top of the form double click into the header section to fill in the date and other requested biographical information.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Initial Assessment:** | Date | **Name:** | *Double click to enter* | **DOB:** |  |

**General Information for managers and clinical staff**

|  |
| --- |
| This section must be completed with a job title or basic job description. It may seem strange we ask for the job title as we refer the patient to you. However, we often receive generic job tittles which do not relate to the day to day activities of the patient. E.g. works in Operations – this can mean on the shop floor at a supermarket or as an on duty firefighter. |

|  |  |
| --- | --- |
| **Job Title or Main Duties:** | *e.g. ‘Delivery driver:*  *Loading white goods to lorry including washing machines of 35kg*  *Pushing goods on cart to delivery address’* |

|  |
| --- |
| The cause of injury should be completed with only one option completed:  **Accident on duty** – the patient must have reported the accident and filled in the paper work to go with it e.g. foot injury from dropping concrete block on foot at work.  **Reported work aggravated** – the patient may have got the injury at home but is aggravated at work e.g. foot injury from dropping concrete block on foot at home laying a patio, patient works in home deliveries  **Domestic** – the patient got the injury at home and it does not affect their job role e.g. foot injury from dropping concrete block on foot patient has sedentary job at a desk |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Cause of injury:** |  | Accident on duty |  | Reported work aggravated |  | Domestic |

|  |
| --- |
| The current work status should be completed with only one option completed:  **At work with pain** – the patient is at work doing their main duties even if they have some pain at work  **On Modified duties** – the patient is at work but has had to limit some of their main duties due to the problem  **Off work** – the patient is unable to work due to their problem (usually has a sick note already) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Current work status:** |  | At work with pain |  | On modified duties |  | Off work |

|  |
| --- |
| The injury site / pain site should be completed and should only include one area (and any related areas) not multiple parts of the body e.g. neck and shoulder but not neck and lower back. This is because we ask for a separate referral for each part of the body. If we didn’t we would never know what the report pertained to i.e. the pain level could be for the neck or the lower back. |

|  |  |
| --- | --- |
| **Injury Site/ Pain Site:** |  |

|  |
| --- |
| The pain level (VAS scale) should be completed and should only include one number. If the patient gives a scale i.e. 2-8 then higher number should be used. |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pain Level:** Patient opinion | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 0 No pain |  | 1 |  | 2 |  | 3 |  | 4 |  | 5 |  | 6 |  | 7 |  | 8 |  | 9 |  | 10 Worst  imaginable |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| The movement/s affected should be completed preferably as a list no medical terms needed. If movement restriction above is listed as 0 then N/A can be put in this box |

|  |  |
| --- | --- |
| **Movement/s Restricted:**  Please list |  |

|  |
| --- |
| The movement restriction should be completed and should only include one number. If there is a scale used i.e. 20-80 then the higher number should be used.  This is the restriction for the worst movement e.g. shoulder flexion, abduction and medial rotation are affected. Flexion is the worst at only 90 degrees range of motion out of 180 – the movement restriction would be 50% |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Movement Restriction:** Physio opinion | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 0% Full range |  | 10% |  | 20% |  | 30% |  | 40% |  | 50% |  | 60% |  | 70% |  | 80% |  | 90% |  | 100%  No movement |

|  |
| --- |
| The overall restriction on ability to work should be completed and should only include one number.    If you are requesting treatment, and the number is 0 it is likely our contracts will not fund the sessions (we will ask). This is because we run an occupational health service directed at improving patients for work. If the patient is able to complete their full duties, then the employer will likely spend the resources on another patient.  If you want the patient to be off work, then the effect on ability to work has to be 100 and in the next section the capabilities at work also has to be unable to work they must match.  The patient can be at work doing all of their main duties but still be affected at work. Using our earlier example, the patient with the sedentary job with the foot injury can sit and type, answer the phone etc. but takes 10 minutes instead of 2 to get to and from the photocopier. In this case effect on ability to work may only be 10% but they are not fully fit.  If you are recommending modified duties then the figure has to be between 10 and 90. |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Overall Effect on Ability to Work (%):** Physio Opinion | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 0% Full role |  | 10% |  | 20% |  | 30% |  | 40% |  | 50% |  | 60% |  | 70% |  | 80% |  | 90% |  | 100%  Unable to work |

|  |
| --- |
| This section is related to the one above and must have one option selected and only one It needs to match the section above. i.e. 0% effect = Capable of normal duties. 100% effect = unable to work. 10-90 is modified duties.  Please note though you can put capable of normal duties here and select 10-90 above if the patient can do their main duties but is still limited somewhat at work (we expect low figures in this case e.g. 10-30). |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Capable of Normal Duties | **From start date:** | **Enter start date here or if left blank the date of the report will be used** |

|  |
| --- |
| Start date for normal duties only needs to be filled out if the date is not the date of the report i.e. you want the modified duties to start in ‘a weeks’ time’ put in the date for ‘a weeks’ time’ away. |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Unable to Work | **Predicted absence time:** | **Enter number of days or weeks or months alternatively enter date at which absence will end** |

|  |  |
| --- | --- |
| Predicted absence should be filled in in days, weeks, months or if a date for return to work is suitable enter the date here. This is only filled out if the patient is off work. |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Modified Duties | **From start date:** | **Enter start date here or if left blank the date of the report will be used** |

|  |  |
| --- | --- |
| Start date for modified duties only needs to be filled out if the date is not the date of the report i.e. you want the modified duties to start in ‘a weeks’ time’ put in the date for ‘a weeks’ time’ away. |  |

|  |  |
| --- | --- |
| The modified duties section is only filled out if you select modified duties above. Each section should have a level in and there should only be one value per section if in doubt err on the side of caution. |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Timed in minutes** | **Unable** | **5** | **10** | **20** | **30** | **60** | **90** | **No restriction** |
| **Sitting** |  |  |  |  |  |  |  |  |
| **Typing and use of mouse** |  |  |  |  |  |  |  |  |
| **Driving** |  |  |  |  |  |  |  |  |
| **Standing** |  |  |  |  |  |  |  |  |
| **Walking** |  |  |  |  |  |  |  |  |
| **Repetitively raising arm above 90 degrees** |  |  |  |  |  |  |  |  |
| **Push / Pull** |  |  |  |  |  |  |  |  |
| **Reaching / Bending** |  |  |  |  |  |  |  |  |

|  |
| --- |
| The max lifting weight should be included if the patient is on modified duties. If you are uncertain about the maximum lifting weight please err on the side of caution. If the carrying weight can is filled as no restriction then the max lifting weight section can be left blank as it is presumed that the lifting weight does not need to be restricted. |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Max lifting weight:**  Physio opinion | | Unable | 2.5kg | | | 5kg | | | | 10kg | | | 15kg | | 20kg |
|  | **Carrying the weight** (mins)**:** | | | Unable | 5 | | 10 | 20 | 30 | | 60 | 90 | | No restriction | |

|  |
| --- |
| The hours able to work should only be completed if modified duties is completed. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Hours able to work:** excluding lunchtime and other breaks | 2 | 4 | 6 | 8 | 12 | Unrestricted |

|  |
| --- |
| The predicted time for modification of duties should have a value selected UNLESS the modifications are permanent in which case this section can be left blank. |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PREDICTED timeframe for continuation and gradual progression of modified duties:** | | | | | | | | | | | | | | | | | |
| **Weeks** | | | | | | | | **Months** | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |

|  |
| --- |
| If the patients role requires permanent modification, then you need to state why in the section below and give an explanation as to the reasoning. This section can be left blank if the section on predicted time frame is completed. |

|  |
| --- |
| **If the role requires permanent changes, explain why here:** |
|  |

**Medical Section: NOT for distribution to anyone not medically qualified**

|  |
| --- |
| The probable diagnosis section should be completed and should not include abbreviations. We appreciate in many cases the diagnosis may well change and may be a judgement at the start of treatment. |

|  |  |
| --- | --- |
| **Probable Diagnosis:**  (based on your findings from the initial assessment) | Please enter the probable diagnosis using full words NOT abbreviations  e.g. ‘Cervical spine facet joint dysfunction with tight and overactive upper fibres of trapezius’  NOT ‘C5/6 RROM with TUFT’ |

|  |
| --- |
| The prognosis section should be completed and should include relevant information for that point in time. We appreciate patients react differently to treatment and the prognosis may change over time.  This section should not include abbreviations    **Note well:** This section should not contain inflammatory or emotive language e.g. *‘if this patient continues in their work role they will never get better* |

|  |  |
| --- | --- |
| **Prognosis:** | Please include any relevant information to the likely progression and outcome for this condition  e.g. ‘The neck is likely to improve over the next 6 weeks with rehabilitation and home exercises. 5 treatment sessions should improve the pain and range of motion and facilitate return to normal duties at work’ |

|  |
| --- |
| This section should only be completed if there are any other details you would like to add. |

|  |  |
| --- | --- |
| **Any Other Relevant Information:** | Please add any additional information here  e.g. ‘The patient is likely to need injection therapy or surgery’  ‘A display screen equipment assessment is recommended’ |

|  |
| --- |
| The number of sessions required should be completed here this is just an estimate please do not estimate high as this does not change the amount of sessions a patient can have but may trigger a scrutiny request. |

|  |  |  |
| --- | --- | --- |
| **Total number of sessions requested to achieve predicted outcome**  (including initial assessment): |  |  |

|  |
| --- |
| Your location (or practise name) and practitioner name should be completed. |

|  |  |
| --- | --- |
| **Location** |  |
| **Practitioner’s Name** |  |

|  |
| --- |
| The patient must have signed consent if the yes box is not ticked then we CAN NOT send the report to the client and sessions cannot continue.  It is OK for the patient to say no they do not want the report to go to their employer. If this is the case, we do not send the report. The employer will not fund sessions of treatment in these cases. This does not mean the patient does not need treatment and we will ask the employer if they will fund it anyway. However, in most cases the patient will need to peruse treatment on the NHS. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Please confirm the patient has signed the consent form to release the report and you are happy for us to forward the report to the client.** | **Yes** |  | **No** |  |   Can the treating Physiotherapist please complete this initial assessment report on the day of treatment and forward to Physio Med **immediately** - Thank you  **Email: XXXXXXXX@physiomed.co.uk Tel No.: 0113 2291305** **Fax No.: 0113 2291310** |  |
| **Physio Med clinical team comments** (for office use only / intended for use by Occupational Healthcare practitioners)**:** |  |