WSBC Patient Paperwork

Orthopedic and Sports Injury Services
1 – 7650 Grant Street, Mission, BC V2V 3T3
Phone: 604-820-8285 Fax: 604-820-8287
info@oasismissionphysio.com

Registered Physical Therapists:

Joe Harvard MSc. PT
Kim Hauvre MSc. PT
Liliana Harvard BSc. PT; Acupuncture Foundation of Canada Certified
Gilbert Lapurga BSc. PT; Certified Work/Functional Capacity Evaluator

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Name:_____ Date of Birth (DD/MMM/YYYY): _____

Address:_____ City:_____ Postal Code:_____

Home Phone: _____
Accept text reminders to this phone ___Yes ___ No

Cell Phone: _____
Accept text reminders to this phone ___Yes ___ No

Work Phone: _____

Email: _____
Accept text reminders to this email ___Yes ___ No

Care Card Number (PHN): _____

My visit is: ____ Private _____ ICBC _____ WSBC

Family Physician:_____ Location: _____

Other treating Physicians (specialist/surgeon) _____

Please indicate how you heard about our clinic: _____

If you would like us to submit claims to a 3rd party payer (Private Insurance, ICBC or WSBC) on your behalf, please complete page 3.

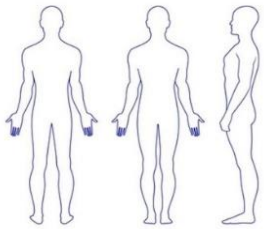
Important Notice to all patients:

- I understand that I am solely responsible for all fees owing to OASIS Mission Physiotherapy. If for any reason those fees are not paid in full by your 3rd party payer, or it was not submitted in a timely manner from our office, you are responsible to pay all outstanding amounts.
- Accounts in arrears for over 6 months are subject to being submitted to a third party to collect on our behalf.
- I understand that one business day cancellation notice is required to be able to offer optimum care to all patients. A $30 late cancellation fee will be implemented if no notice is given. If repeated appointments are missed, clients may be asked to pre-pay for the appointment prior to scheduling. This fee will not be refunded or transferred.

Patient/Guardian Signature:_____ Date:_____

MEDICAL HISTORY

Check off Yes or No for the following conditions								
	Yes	No		Yes	No		Yes	No
Arthritis			Heart Condition			Vision Difficulties		
Osteoporosis			Chest Pain			Swallowing Difficulties		
Asthma			Pacemaker			Slurred Speech		
Bronchitis			Dizziness or Fainting			Memory Problems		
Other Respiratory Condition:			High or Low Blood Pressure			Hearing Impairment		
Cough			Depression			Sleeping Problems		
Diabetes			History of Cancer			Balance Problems		
Thyroid Condition			Smoking History			Recent Falls or Blackouts		
Raynaud's			Pregnancy			Unexplained Weight Loss		
Epilepsy or Seizures			Metal implants (incl. IUD)			Groin Numbness or Tingling		
Blood Disease			Hernia			Allergy to Tape or Latex		
Headaches			Bowel or Bladder Difficulties			Other Allergies:		



Back Front Side

Mark an X on your area or areas of concern.

How is your daily life affected by your condition?

_____

Anything else we should know about your health?

_____

Please list any surgeries, injuries or injections you have had with the approximate dates:

Injuries:_____

Surgeries: _____

Injections:_____

Please list any medications (with dosages) you are currently taking: If you have a list, we will copy it for you.

_____

Do you sleep through the night? ___Yes ___No Do you wake but feel unrested? ___Yes ___No

What position do you sleep in? Lying on: ___Back ___Front ___Side

Check off any test(s) you have had that are related to your referral in our clinic today?

___Bone Density Study ___CT Scan EMG/Nerve Conduction ___MRI ___Ultrasound ___X-rays

Other tests not listed above: _____

Do you have a referral from your doctor? ___Yes ___No

Do you have a follow up appointment with your doctor? ___Yes ___No

I give consent for Assessment and Treatment

Patient/Guardian:_____ Date:_____

JOB DEMANDS

Name:	Date of Birth:	Claim#:
Date of Injury:	Job Title:	Hours per Shift / Shifts per Week
Company Name, Address, Phone Number:		Company Contact Person and Title:
Please provide a short description of your job position:		

We are asked by WSBC to determine what your job involves physically and to contact your employer and confirm the functional demands of your job, so we can determine opportunities for a full or graduated return to work program.

List the top 5 physically demanding tasks you perform each shift that have become difficult with your injury.

1. Describe the activity:

How long do you perform this task without a break? _____

How many times do you perform this activity? _____ How much weight is involved? _____

2. Describe the activity:

How long do you perform this task without a break? _____

How many times do you perform this activity? _____ How much weight is involved? _____

3. Describe the activity: _____

How long do you perform this task without a break? _____

How many times do you perform this activity? _____ How much weight is involved? _____

4. Describe the activity:

How long do you perform this task without a break? _____

How many times do you perform this activity? _____ How much weight is involved? _____

5. Describe the activity:

How long do you perform this task without a break? _____

How many times do you perform this activity? _____ How much weight is involved? _____

Is there anything else you would like us to know about your limitations at work due to your current injury?

I have provided above information to the best of my knowledge.

Patient/Guardian Signature:_____ Date:_____

CONSENT FOR ASSESSMENT AND TREATMENT

Our clinic is committed to ensure you receive quality care and that your privacy is protected.
For the duration of your treatment we request your informed consent to:

- Provide assessment and treatment services to you;
- Collect, use, and share any relevant clinical information

Your physiotherapist will explain the benefits, side effects and potential complications of each chosen technique before use. Physiotherapy treatment techniques may include, but are not limited to:

- Manual techniques;
- Spinal Manipulation;
- Therapeutic Exercise;
- Electrotherapeutic Modalities;
- Other techniques and procedures your treating physiotherapist determines may improve your function.

I understand that I will be informed during my assessment and treatment about the following:

- What to expect in the assessment and treatment;
- Who will perform the assessment and treatment;
- The reasons why I should have the assessment/treatment;
- What might happen if I do not have the assessment/treatment;
- Potential risks and/or side effects for the assessment and recommended treatment. _____ Initials

I understand that I may ask questions at any time and/or share concerns immediately about the recommended and current treatment so the physiotherapist can explain the rationale and/or modify my program appropriately.
_____ Initials

I understand that at any time I choose not to participate in the course of treatment, I will inform my physiotherapist immediately. _____ Initials

I understand I can withdraw my consent in writing for any further treatment. _____ Initials

I understand and agree with the criteria above, and consent voluntarily to participate in the physical and functional assessment and recommended treatment program that is based on my medical history, diagnosis, symptoms and assessment results, delivered by those authorized in this clinic.

Consent for Assessment and Treatment

Patient/Guardian Signature:_____ Date:_____

Physiotherapist Signature:_____ Date:_____

CONSENT FOR RELEASE OF INFORMATION

I agree to give my informed consent to Oasis Mission Physiotherapy to discuss return to work information with my employer or representative as per my discussion with my physiotherapist.

1. Employer or Employer Representative: _____ Yes _____ No _____ Initials

I agree to give my informed consent to Oasis Mission Physiotherapy to disclose and/or obtain medical or other information from the following professionals for the purpose(s) of assessing and/or providing treatment services.

2. Third Party Insurer:

WSBC: _____ Yes _____ No _____ Initials

ICBC: _____ Yes _____ No _____ Initials

Extended Health: _____ Yes _____ No _____ Initials

3. Medical Professional(s):

Family Doctor Name: _____ _____ Yes _____ No _____ Initials

Specialist Name: _____ _____ Yes _____ No _____ Initials

Other Name: _____ _____ Yes _____ No _____ Initials

4. Lawyer (if applicable):

Name: _____ _____ Yes _____ No _____ Initials

5. Other (please provide details):

Name: _____ _____ Yes _____ No _____ Initials

I understand that my consent may be amended or revoked in whole or in part at any time by providing written notice to Oasis Mission Physiotherapy. Please note that revoking consent may have additional consequences such as the withdrawal of treatment or the decline of a payment by a third part payer.

Patient/Guardian Signature:_____ Date:_____