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:_____