Health 2 Work

OW ID#

Health2Work Discharge Report

Patient Information

First Name	Last Name

Date Of Birth (m/d/y)	Phone #	Gender

Address	Postal code

Chiropractor Information

Name	Date of Assessment:

Clinic Name and Address	Phone #

Reason For Report

- ☐ Initial Assessment
- ☐ Re-assessment

History

Physical Exam at re-assessment/discharge:

Results of questionnaires and other tests (for re-assessment please provide previous & current ratings).
Visual Analogue Scale:
Oswestry:
Neck Disability Index:
Other:

Diagnosis/Clinical Impression:

Reason for discharge:

Please comment on patient compliance:

1. Please indicate **abillties** that apply.

Walking:
- ☐ Full abillties
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abillties
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abillties
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist
- ☐ Full abillities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abillities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abillties
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abillties
- ☐ 1 - 3 steps
- ☐ 4 -6 steps
- ☐ Other (please specify)

Travel to work

Abillity to use public transit
- ☐ yes
- ☐ no

Abillity to drive a car
- ☐ yes
- ☐ no

2. Please indicate **restrictions** that apply.

- ☐ Bending/twisting re-petitive movement of (please specify)
- ☐ Work at or above shoulder activity: (please specify)
- ☐ Limited use of hand(s):

	Left	Right
Gripping	☐	☐
Pinching	☐	☐
Other	☐	☐

- ☐ Limited pushing/ pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other

- ☐ Operating motorized equipment:(e.g. forklift)
- ☐ Consult required to determine impact of drugs or other medical conditions
- ☐ Exposure to vibration
  - ☐ Whole body
  - ☐ Hand/Arm

Please check any that apply for patient at discharge:

If client was ***not*** employed or in training program at initial assessment:

- ☐ Employed F/T at discharge
- ☐ Employed P/T at discharge
- ☐ Entering job training at discharge
- ☐ Not ready for employment or job training at discharge
- ☐ Other (please specify)

If client was employed or in training program at initial assessment:

- ☐ Able to stay in same employment at discharge
- ☐ Able to stay in same training program at discharge
- ☐ Changed employment at discharge to:
  - ☐ A) Full-time employment
  - ☐ B) Part-time employment
- ☐ Employed, but in different field at discharge
- ☐ Changed training programs at discharge
- ☐ No longer employed or in training program at discharge
- ☐ Other (please specify)

Comments:

Did patient achieved their primary employment/training goal?

☐ Yes ☐ No

Comments and recommendations for training programs/employment paths

Please send completed Discharge Report to the Lead Chiropractor and Tammy Ingrao, Branch Program Assistant, Region of Waterloo (tingrao@regionofwaterloo.ca, phone: 519-740-5720)

Signature of chiropractor _____ Date _____

Signature of lead chiropractor _____ Date _____