



Workers Compensation Board of PEI
Promoting Safe Workplaces...Protecting Employers and Workers

CHIROPRACTOR REPORT

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- Initial Assessment
 Progress Report
 Discharge Report
 Amended Billing

Claim #	Clinic Name
Name	Address
Injury Date	Phone

Fee Code	PN 99 <input type="checkbox"/>
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Treatment Dates

Total # of Treatments	# Missed Appointments	Reason:
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Initial Diagnosis:	Present Diagnosis:
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Describe Injury History (*Initial Assessment Only*) /Current Subjective Status:

<u>Initial Objective Findings:</u>	<u>Current Objective Findings:</u>
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Goals	Treatment Plan	Time Frames

Education/Home Program Provided

Recommended Work Status:
 Full Duties
 Not Able
 Ease back
 Modified Duties

Conflicting Circumstances:
 None
 Compliance
 Other

Explain:

Chiropractor's Signature: _____	EXPECTED RETURN TO WORK DATE:
Date: _____	

Request for *EXTENSION* of Current Treatment
 Request for *WORK CONDITIONING*

Start Date:	Number of Weeks:	Expected # of Visits:
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Clinical Interpretation:

Extension Goals: