✓ To fill in and save the PDF, download and open in Adobe Reader.

# GP Standard Medical Report

This form is to be completed by the primary care provider, whenever possible.

If applicable, please select the Lock button before submitting the form.
Please note: once the Lock button has been selected, the form will no longer be editable.

Lock

Complete this form if the patient is **ABLE** to fully complete work, training or studying activities, and there is no absence from or reduction to these activities.

If the patient is unable to fully complete work, training or studying activities, complete the **GP Extended Medical Report** instead.

**INVOICE INFORMATION**

| CLAIM NUMBER | DATE OF ACCIDENT (dd/mmm/yyyy) | DATE OF GP REPORT (dd/mmm/yyyy) | VENDOR NUMBER |
|---|---|---|---|
| INVOICE/REFERENCE NUMBER | PAYEE NAME | | |
| PAYEE ADDRESS | | | |
| PAYEE ADDRESS | | | |

**PATIENT INFORMATION**

| FIRST NAME | LAST NAME | DATE OF BIRTH (dd/mmm/yyyy) | PERSONAL HEALTH NUMBER (PHN) |
|---|---|---|---|
| | | | |

**PRACTITIONER INFORMATION**

| FIRST NAME | LAST NAME | MSP/PRACTITIONER NUMBER |
|---|---|---|
| | | |

ARE YOU THE PATIENT'S REGULAR PRACTITIONER?
☐ Yes ☐ No

**SUBJECTIVE**

KEY SUBJECTIVE FINDINGS:

**RELEVANT PRE-ACCIDENT HISTORY**

HAS YOUR PATIENT EVER HAD SYMPTOMS AND/OR RECEIVED TREATMENT/MEDICATIONS FOR THE AREA(S) INJURED IN THIS ACCIDENT?
☐ Yes ☐ No

IF YES, DESCRIBE CONDITIONS/TREATMENT AND POSSIBLE IMPACT, IF ANY, ON RECOVERY:

**WORK STATUS**

1. IS THE PATIENT EMPLOYED OR ENGAGED IN TRAINING ACTIVITIES? PLEASE INDICATE WHICH ONE(S)
☐ Full time ☐ Part time ☐ Self-employed ☐ Seasonal ☐ Training/Apprenticeship ☐ Student ☐ Retired ☐ Not employed

2. HAS THE PATIENT BEEN ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?
Work: ☐ Yes ☐ No Training: ☐ Yes ☐ No School/Studies: ☐ Yes ☐ No

**If the patient is continuing to work, study or train indicate their status, as applicable**

3. STATUS OF DUTIES
Work: ☐ Full ☐ Modified Training: ☐ Full ☐ Modified Study: ☐ Full ☐ Modified

4. STATUS OF HOURS
Work: ☐ Full ☐ Modified Training: ☐ Full ☐ Modified Study: ☐ Full ☐ Modified

## Objective

| PHYSICAL EXAM |
|---|
| KEY OBJECTIVE FINDINGS: |

## Diagnosis

| **PRIMARY DIAGNOSIS —** IDENTIFY THE MOST SERIOUS OR SIGNIFICANT INJURY. | | | |
|---|---|---|---|
| DIAGNOSIS | ICD 9 CODE | DEGREE/GRADE (WAD, SPRAIN, STRAIN) | ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None |
| **OTHER DIAGNOSIS —** IDENTIFY ANY ADDITIONAL INJURIES THE PATIENT HAS SUSTAINED. | | | |
| DIAGNOSIS | ICD 9 CODE | DEGREE/GRADE (WAD, SPRAIN, STRAIN) | ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None |
| DIAGNOSIS | ICD 9 CODE | DEGREE/GRADE (WAD, SPRAIN, STRAIN) | ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None |
| DIAGNOSIS | ICD 9 CODE | DEGREE/GRADE (WAD, SPRAIN, STRAIN) | ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None |
| DIAGNOSIS | ICD 9 CODE | DEGREE/GRADE (WAD, SPRAIN, STRAIN) | ORIENTATION ☐ Left ☐ Right ☐ Bilat. ☐ None |

## Recommended Care Plan Treatment

| **RECOMMENDED PRE-APPROVED TREATMENT(S)** — INDICATE WHICH TREATMENT(S) ARE APPROPRIATE TO ADDRESS THE PATIENT'S INJURY/INJURIES |
|---|
| TREATMENT TYPE |
| TREATMENT TYPE |
| TREATMENT TYPE |
| ADDITIONAL TREATMENT RECOMMENDATION INCLUDING TYPE, FREQUENCY AND DURATION IF APPLICABLE: |

| **TREATMENT NOTES** |
|---|
| PROTOCOLS AND GUIDELINES (e.g. OPTIMa, ODG, etc.)<br>Are you using an established protocol to inform your treatment plan? ☐ Yes ☐ No<br>If applicable, please indicate the protocol for treatment: |
| 5. DO YOU EXPECT THE PATIENT TO RETURN TO NORMAL FUNCTION WITH THE ABOVE RECOMMENDED TREATMENT PLAN?<br>☐ Yes ☐ No ☐ Unable to determine |
| IF "NO" OR "UNABLE TO DETERMINE", PROVIDE COMMENTS: |
| 6. WILL THE PATIENT REQUIRE ADDITIONAL THERAPY BEYOND THE ABOVE RECOMMENDED TREATMENT PLAN?<br>☐ Yes ☐ No |
| 7. HAS MEDICATION BEEN PRESCRIBED FOR THIS INJURY/INJURIES?<br>☐ Yes ☐ No<br>If yes, indicate: |
| 8. ANTICIPATED DATE OF FULL RECOVERY (dd/mmm/yyyy) |

## Patient Education – check any/all that have been communicated to the patient

In accordance with evidence informed best practice, and as applicable to the injuries sustained by the patient, the patient has received education with respect to:

- ☐ the desirability of an early return, without limitation, to being able to perform the activities the patient could perform before the injury and if applicable, to the patient's employment, training or study
- ☐ an estimate of the probable length of time that symptoms will last
- ☐ the usual course of recovery
- ☐ the probable factors that are responsible for the symptoms the patient may be experiencing
- ☐ appropriate self-management and pain management strategies

☐ By checking this box, I certify that the information provided is true and correct to the best of my knowledge.

Select one of the following:

- ☐ I have obtained consent from the patient to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.
- ☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

Personal information on this form is being collected under Section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and Section 28 or 28.1 of the *Insurance (Vehicle) Act (BC)* for the purpose of obtaining a health care report in order to investigate, manage or settle a claim. Questions about the collection of this information may be directed to the adjuster, or call 604-661-2800 or contact the Privacy & Freedom of Information (FOI) Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.

**Return To** ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6

**Fax** 1-877-686-4222