MANITOBA PUBLIC INSURANCE

PRIMARY HEALTH CARE REPORT

Claim #:

Surname of Patient: | Given Name: | DOB. Yr. Mo. Day | Case Manager

Address | Occupation

Date of this examination: Yr. Mo. Day | Date of Collision: Yr. Mo. Day

Yes	No	Following the collision did the patient:	Yes	No
☐	☐	1. Sustain a blow to the head?	☐	☐
☐	☐	2. Sustain a loss of consciousness? If yes, duration?	☐	☐
		3. Sustain an abrasion, contusion or laceration? (list site)	☐	☐
		4. Have any investigative tests been performed? If yes, please **enclose all results.**		
		5. Seek health care within 24 hours of collision?		

Mechanism of Collision: (with respect to the patient's vehicle)

☐ Rear impact ☐ Frontal impact ☐ Side impact ☐ Other

Symptoms: Check all that have developed as a result of the collision:

L	R		L	R		L	R		L	R	
☐	☐	Neck Pain	☐	☐	Interscapular Pain	☐	☐	Hip/Thigh Pain	☐	☐	Dizziness
☐	☐	Headache	☐	☐	Chest Pain	☐	☐	Knee/Leg Pain	☐	☐	Tinnitus
☐	☐	Shoulder/Arm Pain	☐	☐	Thoracic/Rib Pain	☐	☐	Ankle/Foot Pain	☐	☐	Impaired Memory
☐	☐	Elbow/Forearm Pain	☐	☐	Abdominal Pain	☐	☐	Facial/Jaw Pain	☐	☐	Sleep Disturbance/Fatigue
☐	☐	Wrist/Hand Pain	☐	☐	Low Back Pain	☐	☐	Blurred Vision	☐	☐	Anxiety/Depression

Physical Signs: Check all physical findings that have developed as a result of the collision:

☐ ☐	Limited Neck ROM	☐ ☐	Interscapular Tenderness	☐ ☐	Limited Hip ROM	☐	Cervical Segmental Dysfunction
☐ ☐	Neck Tenderness	☐ ☐	Chest Tenderness	☐ ☐	Limited Knee ROM	☐	Thoracic Segmental Dysfunction
☐ ☐	Limited Shoulder ROM	☐ ☐	Thoracic/Rib Tenderness	☐ ☐	Limited Ankle/Foot ROM	☐	Lumbar Segmental Dysfunction
☐ ☐	Shoulder/Arm Tenderness	☐ ☐	Abdominal Tenderness	☐ ☐	Hearing Deficit	☐	Impaired Memory
☐ ☐	Elbow/Forearm Tenderness	☐ ☐	Lumbar Tenderness	☐ ☐	Visual Field Deficit	☐	Disorientation
☐ ☐	Wrist/Hand Tenderness	☐ ☐	Limited Lumbar ROM	☐ ☐	Nystagmus	☐	Mood Alteration

Neurological Examination (Objective):

☐ Normal ☐ Dural Tension | ☐ Sensory Deficit Cutaneous Territory _____ | ☐ Motor Deficit Muscles Affected _____ | ☐ Reflex Changes Levels Affected _____

Yes	No	In the 5 years prior to the collision, did the patient:
☐	☐	1. Take time off work >4 weeks because of a previous injury or health problem?
☐	☐	2. Use prescription or OTC medications on a regular basis?
☐	☐	3. Experience any significant health problems requiring ongoing care?
☐	☐	4. Receive any Chiropractic or Physiotherapy treatment? If yes, list date of last treatment.

Clinical Diagnosis:

Work Status: Is the patient currently at work? ☐ Yes ☐ No In no, indicate targeted return date

Yes	No	Does the patient's clinical condition:	Yes	No	
☐	☐	a) Preclude travel to and from the workplace?	☐	☐	c) Pose a safety/health risk to the patient or their co-workers?
☐	☐	b) Result in an inability to perform any required tasks?	☐	☐	d) Will a return to the workplace adversely affect the natural history of the clinical condition?

Management Plan: Circle and complete as many as appropriate

1. List any prescribed medication:
2. List any prescribed splints or other assistive devices:
3. Has a referral been made to another healthcare practitioner? If yes, where?
4. Anticipated frequency (in next 6 wk.) of in-clinic care.
5. Total forecasted duration of in-clinic care:

Identity of Practitioner: [PLEASE PRINT]

Surname: | Given Name: | Manitoba Public Insurance Registered Acct #

Address (Number, Street, Apt. No)

City | Prov. | Postal Code | Tel. No. (Area Code) | Fax #.

Though this report is essential, the patient must file a claim with the Manitoba Public Insurance Corporation before a compensation file can be opened.

Signature of Practitioner | Yr. Mo. Day Date:

Authorization of Patient or Guardian

I hereby authorize the release of this report to Manitoba Public Insurance Corporation in support of my claim.

Signature – Patient or Guardian | Date

If you wish to discuss this patient with one of our physicians or chiropractors, please phone 204-985-7395

20-019-2619