

Employee Request for Extension of Physiotherapy Benefits

CUPE 5167

This form is to be completed by your treating practitioner. Cost associated with the filling of this form is the responsibility of the employee requesting the benefit entitlement extension. Forms must be completed in full for consideration. If an extension of the physiotherapy benefits is approved a progress report is to be submitted, by the treating practitioner, to Return to Work Services every 4 weeks including a discharge report.

Questions about the completion of this form should be directed to your CUPE 5167 representative.

Employee Name (Print):	Employee Signature:
Employee Number:	Job Title:
Department:	Date

TO BE COMPLETED BY THE EMPLOYEE

1. Do you have physiotherapy coverage available under an alternate plan? Yes No (Examples of alternate plans include spousal coverage, auto accident benefit carrier, WSIB coverage)
2. Is this request for an extension of current ongoing treatment? Yes No If yes, date current treatment program started:

TO BE COMPLETED BY THE TREATING PRACTITIONER

Complete the following if this request is for a new physiotherapy treatment plan

1. What is the treatment plan? (Include active and passive modalities)
2. What is the goal of the treatment plan?
3. What is the duration of the plan, in weeks and frequency per week?
4. Is there a specialist protocol associated with this treatment plan, e.g. orthopedic surgeon hip replacement protocol?

Complete the following if this request is for a continuation of a current physiotherapy treatment plan

1. Current program start date?
2. Frequency of sessions per week?
3. Duration of treatment plan (if extension is approved)?

4. What is the treatment plan? (Include active and passive modalities)
5. What, if any, are the extenuating factors that have resulted in your treatment program being longer than normally expected for similar conditions?

According to the College of Physiotherapists of Ontario “Physiotherapists assess, treat and prevent physical problems, injuries and pain, to restore movement, function and health status.”

6. Please explain how extending treatment will assist in meeting the above stated goal?
7. Is the intent of this program to improve function or maintain function?
8. Is this plan transitioning to a home program? Please provide details of transition plan or rationale for not transitioning
9. Is there a specialist protocol associated with this treatment plan, e.g. orthopedic surgeon hip replacement protocol?

Treating Practitioner Name

Date

Clinic Name and Location: