



# Purcell Physiotherapy

## Work Safe BC Patient Intake Form

Date: \_\_\_\_\_

First Name:			Last Name:		
Guardian (if minor):					
D.O.B: M      D      Y		Age:		Gender: M / F / Other	
Home Address:					
City:		Province:		Postal Code:	
PHN # (MSP care card):					
Home Phone:		Cell Phone:		Work Phone:	
Do you want to receive text reminders for your appts?    Yes   /   No					
Your occupation:			Email:		
Injury:			Surgery Date (if applicable):		
Family Doctor:			Referring Dr:		
<u>Emergency contact Information:</u>					
Name:		Relationship:		Phone #:	
How did you hear about us?					

### Release of Information

I give Purcell Physiotherapy my consent to release/obtain/share information from the following individuals with respect to my care (via email/mail/fax/ or phone) as well as give a verbal report of my assessment, treatment plan, interim report, discharge plan and follow up reports.

Physician(s): \_\_\_\_\_ Phone: \_\_\_\_\_ Initial: \_\_\_\_\_

\*If applicable:

Other Physiotherapist: \_\_\_\_\_ Initial: \_\_\_\_\_

Other Health professionals: \_\_\_\_\_ Initial: \_\_\_\_\_



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Work Safe BC

Claim #: \_\_\_\_\_

Date of Injury/Accident: \_\_\_\_\_ Has this claim been accepted? \_\_\_\_\_

Case Manager (if assigned one): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Injured Body parts: \_\_\_\_\_

\* I understand that Purcell Physiotherapy will be in contact with Work Safe BC in regards to my treatment. Initial: \_\_\_\_\_

\* I understand my physiotherapist will be contacting your employer to confirm job duties. Please discuss this with your physiotherapist if you have any concerns. Initial: \_\_\_\_\_

\* If my WSBC claim is not accepted, I understand that payment for physiotherapy services after the initial appointment, are my responsibility to pay. Initial: \_\_\_\_\_

\* If you miss more than one scheduled appointment without notice, you may be discharged from receiving further treatment. This may affect the status of your claim. Initial: \_\_\_\_\_

### No-Show Policy

- I understand that it is my responsibility to be present and invested in my treatment at Purcell Physiotherapy, so that I can heal and return to work and regular life. Initial: \_\_\_\_\_

- Just like if I don't show up for work, I could be fired, if I miss too many physio appointments I could be discharged and it may affect the status of my claim. Initial: \_\_\_\_\_

- Purcell Physiotherapy requires **at least** an hour notice when cancelling. One missed appointment will result in a verbal warning and after the 2<sup>nd</sup> they may be contacting my case manager and discussing the possibility of discharging me as a patient. Initial: \_\_\_\_\_



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### Consent for Treatment

- I, the undersigned, grant permission to the physiotherapist to assess and provide treatment as discussed during the initial visit. I will be given a full explanation of these interventions to be used and the potential risk/benefits of them. I will tell my therapist if I have not received enough information or do not fully understand. I understand that I have the right to refuse treatment at any time.
- I understand that by entering this public building, there is a risk of being exposed to the COVID-19 virus. I agree that if I have any symptoms (fever, chills, shortness of breath, difficulty breathing or cough) I will let Purcell Physiotherapy know prior to my appointment.

Signature : \_\_\_\_\_  
(guardian, if minor)

Date: \_\_\_\_\_

Witness (clinic staff): \_\_\_\_\_

Date: \_\_\_\_\_