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**Physiotherapy Report in Vocational Rehabilitation**

**Progress of Treatment**

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| ***Service order number (Númer þjónustupöntunar):***       | ***VIRK counsellor´s name (Nafn ráðgjafa):***       |
| ***It is requested that the report will be submitted within two weeks.*** | *N.B. Please send the completed report by email to the VIRK counsellor. The VIRK service order number must be entered in accordance with the information from the VIRK counsellor.* |

***Treatment time and attendance***

***When (approximately) did the treatment for the current problem begin?***

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***Attendance since the treatment began***

[ ]  In accordance with the treatment plan

[ ]  Below expectations but solid explanations for any absences were provided for

[ ]  Far below standards (has repeatedly cancelled / forgotten classes / not attended / not

 cancelled)

***Motivation and commitment***

***Is the individual interested in learning about physical condition and ready to take action to preserve or improve one´s own physical health?***

[ ]  Yes

[ ]  No

[ ]  I’m not sure

***Does the individual make use of the instructions received from the physiotherapist.*** *(E.g., instructions on the importance of training, responsibility for own health, proper posture and body mechanics, resting positions)*

[ ]  Yes

[ ]  No

[ ]  I’m not sure

***Does the individual take responsibility for recommended training?***

[ ]  Yes

[ ]  No

[ ]  I’m not sure

***Goals that have been worked on during the current treatment*** ***session***

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***Have all the goals for the treatment session been met?***

[ ]  Yes

[ ]  No

***If no, which goals have not been met? Please provide further details***

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***Assessment of physical barriers to employment (examination results)***

***Which physical factors are still hindering for work?*** (Based on the ICF model, see details at skafl.is)

Please note that more than one option can be selected from the following list

[ ]  Being in a standing position (ICF d4154) / Working in a standing position

[ ]  Being in a sitting position (ICF d4153) / Working in a sitting position

[ ]  Walking (ICF d450)

[ ]  Lifting and carrying objects (ICF d430)

[ ]  Fine motor skills / Fine hand use (ICF d440)

[ ]  Exercise tolerance functions (ICF b455)

[ ]  Vestibular functions – (ICF b235)

[ ]  Sensation of pain – (ICF b280)

***Further information on physical barriers to work***

Brief description on examination results

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***Please provide a list of the measurement tools that were applied, and outcome measures*** (E.g., ODI, NDI, FIQ ...)

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***Overall progress of treatment and current status***

[ ]  Improving condition

[ ]  Status quo

[ ]  Deteriorating condition

***A more detailed description of the progress of treatment***Optional

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***The physiotherapist’s treatment plan***

Please note that more than one option can be selected from the following list

[ ]  Individualized instructions/education

[ ]  Exercise therapy

[ ]  Hands-on physiotherapy remedies

***If hands-on physiotherapy remedies are required, what is the estimated duration of the treatment planned and the number of individual sessions?***

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***Other important comments regarding the treatment plan the physiotherapist would like to add?*** Optional

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***Suggestions for programs or services provided by other professionals***

Please note that more than one option can be selected from the following list

[ ]  Exercise therapy/training

[ ]  Musculoskeletal education sessions

[ ]  A course on how to cope/live with persistent pain (e.g., ACT or CBT)

[ ]  Workplace assessment

***Other courses/education recommended?*** Optional

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***Is there a need for the involvement of other professionals?*** Optional

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***If exercise therapy or training is recommended, please explain what is recommended***

Please note that more than one option can be selected from the following list

[ ]  Individualized exercise therapy guided by a physiotherapist

[ ]  Group training

[ ]  Gym membership card

***Any additional comments regarding exercise therapy/training on behalf of other professionals?*** Optional

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***Status regarding return to work (despite symptoms and/or impairments)***

[ ]  The individual is neither ready for a work trial nor for work in general

[ ]  The individual is ready for a work trial

(6-8 weeks of incremental work participation, from a minimum of 4-6 hours per week up to a maximum of 20 hours per week/50% job percentage)

[ ]  The individual is ready for part-time work (40-70% job percentage)

[ ]  The individual is ready for a high job percentage/full employment or a job search

(70-100% employment ratio)

[ ]  The individual is working part-time

[ ]  The individual’s motivation for work is unclear

***Is it realistic for the individual to aim for the same/similar type of work as before, or will it be necessary to look for another field of work?***

[ ]  It is realistic for the individual to aim for the same field of work as before

[ ]  The individual needs to change the field of work due to existing impairments

[ ]  It is not clear at this point

[ ]  None of the above applies

***Any additional comments?*** Optional

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**Confirmation of the physiotherapist**

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| ***Date:***       |
| ***Name of physiotherapist:***       |
| ***Workplace:***       |