OATA

For internal use only

Form identification no. _____

Acute Low Back Injuries Discharge Report

A. Patient Demographics

Practitioner Identification No.: _____ Patient Identification No.: _____
(Please provide a random patient identifier number)

1. Gender: ☐ Male ☐ Female
2. Age Group: ☐ 0-14 ☐ 15 – 24 ☐ 25 – 34 ☐ 35 – 44 ☐ 45-54 ☐ 55-64 ☐ 65+

B. Clinical Information

3. (a) Patient completed Program of Care: ☐ Yes or (b) Patient did not return/self-discharged from Program of Care: ☐ Yes
4. (a) Specify date of first visit: mm | dd | yyyy

   (b) Specify date of last visit: mm | dd | yyyy
5. (a) Summary of physical findings at discharge:

   (b) Summary of significant changes from initial assessment:
6. (a) At Assessment

   Record Numeric Pain Rating Score / 10 (e.g. no pain = 0, worst possible pain = 10)

   (b) At Discharge

   Record Numeric Pain Rating Score / 10 (e.g. no pain = 0, worst possible pain = 10)
7. (a) At Assessment (Please Select One of the following)
   Indicate Pain

   ☐ No low back pain ☐ Low back pain without radiation ☐ Low back pain radiating no further than the knee ☐ Low back pain radiating below the knee, no neurological signs ☐ Low back pain radiating to a precise dermatome, with or without neurological signs

   (b) At Discharge (Please Select One of the following)
   Indicate Pain

   ☐ No low back pain ☐ Low back pain without radiation ☐ Low back pain radiating no further than the knee ☐ Low back pain radiating below the knee, no neurological signs ☐ Low back pain radiating to a precise dermatome, with or without neurological signs
8. (a) At Assessment
   Record patients Roland – Morris Disability Questionnaire score: /24

   (b) At Discharge
   Record patients Roland – Morris Disability Questionnaire score: /24

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9. (a) At Assessment
Describe patient's limitations in Activities of Daily Living:

☐ Child care ☐ Hobbies ☐ Housekeeping ☐ Self-care ☐ Sleep disturbance
☐ Sports/Leisure Activities ☐ Other (please specify)

(b) At Discharge
Describe patient's limitations in Activities of Daily Living:

☐ Child care ☐ Hobbies ☐ Housekeeping ☐ Self-care ☐ Sleep disturbance
☐ Sports/Leisure Activities ☐ Other (please specify)

10. Has the patient returned to pre-injury level of overall function? ☐ Yes ☐ No

11. Are there any complicating factors (yellow flags) that may delay recovery: ☐ Yes ☐ No

If yes, identify:
☐ Believes hurt equals harm ☐ Home environment concerns ☐ Fears/avoids activity
☐ Low mood/social withdrawal ☐ Prefers passive treatments ☐ Other (please specify)

12. Please indicate if any of the following are required:

Additional treatments	☐ Yes	☐ No	
Additional re-assessments	☐ Yes	☐ No	
Referrals	☐ Yes	☐ No	If yes, to whom were the referrals made? (e.g. other health professionals) [Do not provide names]

C. Summary of Care Delivered

13. Program of Care
(a) Interventions Supported by Evidence

	Program Weeks: Phase I Weeks 1-4	Phase II Weeks 5-8
Reassurance	☐	☐
Explanation of injury, positive course of recovery	☐	☐
Promotion of daily activities	☐	☐
Emphasis on restoration of function	☐	☐
Instruction and supervision of stretching exercises	☐	☐
Instruction of self-application of heat and ice	☐	☐
Use of non-prescription analgesics and non-steroidal anti-inflammatory drugs	☐	☐
Exercise graduated, structured, quota-based	☐	☐

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(b) Interventions Not Supported by Evidence and Not Recommended

Acupuncture	☐	☐
Bed-rest	☐	☐
Electrical stimulation	☐	☐
Flexion exercises	☐	☐
Mechanical traction	☐	☐
Ultrasound	☐	☐
Transcutaneous electrical nerve stimulation (TENS)	☐	☐
Other (please specify)	☐	☐

14. Visits Summary

Total number of treatment visits during Program of Care: Phase I Weeks 1-4 _____ Phase II Weeks 5-8 _____

15. Total number of treatment visits: _____

» Submit

Under no circumstances is private or confidential personal patient information to be disclosed to the OATA or third party.

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