

Part 1. Claimant Information

Last Name		First Name		Middle Name(s)	
Mailing Address				City or Town	
Province	Country	Postal Code	Email Address		
Telephone Number	Date of Birth (dd-mm-yyyy)		Date of Accident (dd-mm-yyyy)		
Policy Number (if known)			Claim Number (if known)		
Insurance Company					

Part 2. Health Care Practitioner Information

Full Name of Health Care Practitioner			
Profession			
Professional License Number, Registration Number, Association Membership Number as applicable			
Mailing Address			
City	Province	Country	Postal Code
Clinic Name		Administrative Contact's Full Name	
Telephone Number		Fax Number	
Email		Preferred Contact Method	
		☐ Phone ☐ Email	

Range of Motion (ROM) loss is evaluated by measuring active ROM with the aid of a measuring device (e.g. goniometer or inclinometer) according to standardized position and technique. Using the following procedure, record the following measurements on the form provided below:

- After adequate warm-up, record **three** trials to the nearest 5° and take the average of the three with evidence of maximal effort. If there is any question of whether adequate effort is provided, please indicate this **on the report**;
- Record both sides of the body to allow for comparison, regardless of whether one or both sides are injured or if a non-affected side had a pre-existing pathology. Please indicate if either side has any obvious pathology present that is unrelated to the accident.

Which joint(s) is affected?

☐ Ankle ☐ Wrist ☒ Toes ☐ Fingers ☐ Thumb ☐ Shoulder ☐ Hip ☐ Knee ☐ Elbow

Range of Motion Loss — Toes

Which foot is the affected joint on?

☐ Left ☐ Right



Questions

Is there a range of motion restriction in the big toe?

☐ Yes ☐ No

If yes, provide details:

Is there a range of motion restriction in any other toes?

☐ Yes ☐ No

If yes, list all other toes with a range of motion restriction and provide details:

Has the claimant's injury become static or stabilized?

☐ Yes, the impairment unlikely to change significantly with further therapy ☐ No

If no, please note any factors contributing to the injury's ongoing instability

Have you treated this claimant before?

☐ Yes ☐ No

If yes, are today's measurements consistent with previous ones?

☐ Yes ☐ No

If no, please specify

Part 4. Health Care Practitioner Signature

I certify that the information provided is true and correct to the best of my knowledge.

Full Name of Health Care Practitioner (Please Print)

Date Report Completed and
Signed (DD/MM/YYYY)

Signature