Occupational Therapy – Upper Limb Treatment Management Plan SAMPLE

Contact details

Worker's name A. Worker **Claim No.** WC1234

Occupation Welder/Boilermaker **Employer** Frank's Fabrication

Referring medical practitioner Dr F.L. Good **Insurer** WC Insurance Ltd.

Workplace rehabilitation provider (if applicable) n/a

Clinical assessment

Date of injury 4/1/19 **Date of initial consultation** 11/1/19

Number of consults to date 12 **Number of consults since last surgery (if applicable)** n/a

Provisional Diagnosis/Diagnosis Right Distal Radius fracture. Persistent ulna sided wrist pain

Area/s treated Right wrist/hand

Clinical Evaluation/Objective Assessments

Presenting complaint

4 months post right distal radius fracture (managed conservatively) following fall on outstretched right hand.
Persistent ulna sided wrist pain exacerbated by functional use.
Reduced wrist ROM and weakness limiting functional use and return to full duties at work.

Objective measurements *e.g. Observation, ROM, Strength, Sensation, Provocative Testing and Pain & Function.*

24/04/19

AROM	*Right*	*Left (unaffected)*
Wrist e/f:	*40-35*	*70-70*
Wrist r/u dev:	*10-10*	*15-25*
Forearm s/p:	*65-70 (7/10 pain)*	*80-80*

Strength (kg/F)	*Right*	*Left (non-dominant)*
Gross Grip (Jamar setting II)	*26*	*52*

Provocative Testing:
Pain on palpation TFCC fovea
Pain reproduced on TFCC stress test
Pain
Pain reported as 7/10 with activity (at worst) and 3/10 as rest

Screening Tools/Questionnaires *(e.g. Orebro/DASH etc)- comment on change over time*

DASH:	**24/04/19**
ADL's:	60/100
Work module:	70/100

**patient has reported improvement in function over the last month, however nil change in pain report to date.*

Functional/ Return to Work Limitations *E.g.: Impairment(s) preventing full work performance*

Persistent wrist pain is limiting return to pre-injury duties at work including use of spanners and tools, use of welding equipment, lifting sheets of metal over 5kg

Biopsychosocial Factors

Have you have identified, or are you aware of any factors that may impact the workers return to work/barriers for return to work? If so, what are they and do you have any recommendations for addressing them?

E.g. diagnostic imaging, specialist referral or referral to other AHP, reassurance, education regarding injury and treatment expectations, work site assessment, etc.

Persistent ulna sided wrist pain with provocative tests suggestive of possible TFCC tear/involvement indicates that specialist referral for further assessment/investigations may be appropriate as per last report to GP.

Current Work Status

Hours

Pre-injury hours at work: 38 per week
Current hours at work: 38 per week

Current duties

- ☐ Pre-injury duties
- ☒ Alternative/modified duties
- ☐ Not working

☐ I would like more information about the duties and the associated physical demands of the workers pre-injury occupation/available duties

Return to Work Progression

Has the worker's hours and/or duties progressed in the last six weeks? ☐ Yes ☒ No

Provide details

Remains on light duties at work on account of persistent wrist pain, weakness and stiffness.

Is the worker likely to return to the functional capacity required to perform their pre-injury duties?

- ☒ Yes — Anticipated timeframe: Dependent on further assessment findings
- ☐ No — Comment:
- ☐ Unsure — Comment:

Do you have any comments to assist the medical practitioner certify capacity for the worker?

e.g. consider current functional measures, modifications to the workplace

As above.

Proposed Management plan

Future Goals – Treatment should be specific and focused on improving function and return to work.

Increase pain free wrist functional use and return to pre injury duties at work

Treatment Type	Frequency	Estimated Timeframe
Wrist Proprioceptive and dynamic stabilisation strengthening program	1-2x week	3 months
Supportive splinting for TFCC (warrior cuff, widget)		
Active, passive ROM and graded strengthening to tolerance		
Pain management/strategies/education		

Have self-management strategies been implemented? ☒ Yes ☐ No

Occupational Therapist's Details

Name: Jill Function — Telephone: 09 999 9999

Email address: jill@functionOT.com

Practice: Function Occupational Therapy — Date: 26/04/10

A copy of this form has been sent to (please tick):

☐ Insurer/Self-insurer ☐ Medical Practitioner ☒ Worker ☐ Other (Specify)

Insurer approval

Note to insurer: It is expected that a response be provided to the therapist within three to five business days of receipt of this TMP.

☐ Approved ☐ Not Approved ☐ Further information required (specify)

Insurer contact name: — Telephone:

Signature: — Date: