



Canadian Society of Medical Examiners Report Writing Guidelines for Physical Impairments

Preamble

These guidelines address issues that are typically important to the provision of a thorough/comprehensive report of an independent medical evaluation (IME) in any realm of practice.

IME's occur in a variety of circumstances and may have many purposes. Individual cases differ also with respect to the nature and/or degree of injury, impairment and disability. It is therefore clear that the contents of a given report will necessarily reflect the relative importance of many specific factors, and processes, as these relate to the individual's injuries and functions, and to the focus of concern and questions of requesting parties.

These guidelines recognize that professional reports of independent evaluators will appropriately reflect clinicians' needs to integrate their understanding of the most relevant factors as these apply to specific cases, and issues, in a manner that can reasonably be understood by the reader. They are not a one-size-fits-all formula for report writing, nor do they represent specific/minimal standards of practice. They are meant to assist independent evaluators in their efforts to clearly present the matters that are most relevant to understanding the objective medical effects of an injury or illness on an individual's abilities to function in various realms.

Examiner Identification

- Qualifications

Consent

- Nature and purpose of examination
- Release of information
- No doctor – patient relationship
- Responsibility to inform examiner
- Confirmation of understanding
- Witnessed signing of consent

Relevant Personal History

- Patient's age
- Patient's marital status
- Dependents and special needs
- Household activities and ADL's
- Interests and recreational activities

Occupational History

- Job title, company & length of employment
- Job requirements
- Performance reviews
- Relationship with management
- Past jobs and reasons for changing them
- History of occupational injury

Past Medical History

- Significant illnesses
- Diagnostic tests
- Hospitalizations
- Surgical procedures
- Medications
- References to the care provided by specific practitioners
- Significant negatives relative to presenting problems

History of Trauma (for trauma-related examinations)

- Record of all prior accidents
 - injuries
 - treatments / response
 - disability duration
 - residua
- Mechanism of assessed trauma
 - speeds
 - points of impact
 - secondary impacts
- If IME is for an MVA
 - Position of individual in vehicle
 - Type of seatbelt restraint/headrest
 - Airbag equipped?/deployed?
 - Interior bodily impacts
 - Individual's ability to exit the vehicle independently
- Immediate symptoms
- Ambulance attendance and transfer details
- Hospital care; x-rays, diagnostics and treatments

History of Illness (for non-trauma examinations)

- Onset of symptoms
- Primary care provided
- Diagnostic work-up

Course of Treatment

- Physician follow up
- Medical referrals
- Diagnostic studies
- Pharmacotherapy / perceived response
- Surgical treatments
- Physical treatments
 - modalities
 - frequency
 - active program components
 - self-directed effort
- perceived responses to all treatments

Current Symptoms

- Symptoms in order of severity
- Prior history of similar or exact symptoms
- Symptom characteristics
 - symptom description
 - location
 - frequency
 - duration
 - radiation
 - aggravating factors
 - alleviating factors
- Complete functional inquiry

Occupational Status and Activities of Daily Living

- Hand dominance
- Job availability: regular, modified or graduated
- Return to work attempts
- Perceived barriers to return
- Ability to complete self-care
- Ability to complete housekeeping, home maintenance, care giving
- Ability to complete recreational and other activities of daily living.
- Other reported restrictions

Clinical Findings

- Blood pressure, pulse.
- Head exam
 - palpatory skull and facial bones
 - cranial nerves
 - temporomandibular joints
 - masses
- Cervical spine
 - palpatory
 - passive / active range of motion.
- Upper extremity
 - palpatory
 - passive / active range of motion for all joints
 - dermatomal sensation
 - myotomal assessment, reflex assessment
- Thoracic spine
 - palpatory findings
 - range of motion
- Chest assessment
 - auscultatory
 - palpatory examination
- abdominal assessment
 - auscultatory
 - palpatory

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- Lumbar spine
 - palpatory findings
 - range of motion
 - straight leg and femoral stretch signs

- Lower extremity
 - palpatory findings
 - passive / active range of motion
 - myotomal muscle assessment / reflexes
 - dermatomal sensory assessment
 - gait assessment

- documented change in symptom status at end of exam

Review of Documents

- list of documents reviewed
- balanced referencing of documents

Summary of Clinical Findings and Conclusions

- diagnostic impression
- determination and reference to relevant and missing documentation
- determination of required diagnostic tests
- description of clinical impairments
- analysis of causality

Response to Questions

- questions dictated
- questions answered concisely and clearly

Last Updated April 2004