

M007 ACUPUNCTURE SERVICES FIRST REPORT

Please print clearly or type.				١	WCB Claim Number	
Surname	First Name and	Initial			Date of Birth (yyyy/mm/dd)	
Address	City/Town		Province	e	Postal Code	
Telephone Number		l	1	Date of Accident		
Referring Physician					Date of Referral	
Diagnoses				[Date of Examination	
Complaints (nature and site)				·		
Level of Pain 1 LOW []	5 r a psych claim, please rate the l	10 ☐ HIGHlevel of anxiety above				
Objective Findings: Ad	cute					
Treatment Provided: ☐ Acupuncture ☐ Cups ☐ Other (describe):	☐ Moxabustion ☐ GUA/	SHA	cture	☐ TDP	Lamp	
Has the worker returned to w ☐ Yes ☐ No	vork? If yes, please p		t-time] Modifie	ed or Alternate Work ☐ Fulltime	
Can the worker return to pre ☐ Yes ☐ No	-accident employment?	If no, describe work re ☐ Temporary ☐ Per			ration:	
Do you wish a Case Manage ☐ Yes ☐ No	er Health Care Provider?		\$	Specialty Area		
Name and Address to Whom Fee is Payable (print)		Signature			Date (yyyy/mm/dd)	
					,	
		Clinic Name				
WCB Billing Number:		Telephone Number		Fax Nun	nber number please provide email address)	