

<b>WORKER DETAILS</b>			WCB Claim Number
Surname		First Name and Initial	Date of Birth: (Year / Month / Day)
Address: Apt/Unit		Street	City/Town Province
Postal Code:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number:	
Worker's Job Title/Occupation:		Progressive Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury: (Year / Month / Day)
Describe how and when the injury/condition occurred.			Date of Exam: (Year / Month / Day)
<b>Examination</b> Symptoms:			
Objective Findings:			
Diagnosis:			
Diagnostic Code 1:		Diagnostic Code 2:	Diagnostic Code 3:
Part of body:	Side of Body:	Nature of Injury:	
Are you aware of any prior conditions in the same anatomical area? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, describe	
Was any diagnostic imaging completed (X-ray, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was the diagnostic imaging completed within your clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnostic imaging type:		Diagnostic imaging facility:	
Diagnostic imaging interpretation			Diagnostic imaging date (Year / Month / Day)
Treatment Plan:			
Frequency and Duration:			

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Any complicating factors affecting recovery?  Yes  No If yes, describe

WCB assisted services required?  
 Contact with WCB case manager  Contact with WCB WCB chiropractic consultant  Referral to Return to Work provider

Treatment Complete  Yes  No If yes, discharge recommendations

Has the worker missed work beyond the date of accident?  Yes  No Has the patient returned to work?  Yes  No If yes, Date (Year / Month / Day)

If returned to work, what is the worker's current work status?  Full duties and hours  Modified Hours \_\_\_\_\_  Modified duties

Job Requirements:

If patient is currently not working or is working modified duties, complete the following. Please make a selection below as they relate to the injury:

Sitting	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited to ____ Hours	Climbing	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited
Standing	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited to ____ Hours	Lifting	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited, Max of ____ (lbs/kg)
Walking	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited to ____ Hours	Pushing / pulling	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited
Bending	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited	Overhead reaching	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited
Twisting	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited	Driving	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited to ____ Hours
Kneeling/squatting	<input type="checkbox"/> Able	<input type="checkbox"/> Unable	<input type="checkbox"/> Limited	Other reasons why the patient cannot work:			
				<input type="checkbox"/> Hospitalized	<input type="checkbox"/> Self reported pain	<input type="checkbox"/> Opioids/Medication side effects	

Other restrictions or additional comments/special considerations:

Estimated Return to Work to pre-accident work date (Year / Month / Day) or  permanent restrictions anticipated

Name and address to whom fee is payable: (please print)	Provider's Signature:	Printed Name:
	Provider's Reference Number	Date (Year / Month / Day)
	Telephone Number	Fax Number