wcb Workers' Compensation Board – Alberta

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C352
CHIRO PROGRESS/DISCHARGE REPORT

WORKER DETAILS

Surname	First Name and Initial		WCB Claim Number Date of Birth *(Year / Month / Day)*
Address *Street*	*City/Town*	*Province*	Postal Code / Telephone Number

Symptoms:

Objective findings:

Change in diagnosis? ☐ Yes ☐ No If yes, describe

Diagnostic Code 1	Diagnostic Code 2	Diagnostic Code 3	Part of body:	Side of Body:

Nature of Injury:

Treatment plan:

Frequency and duration:

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

General prognosis/remarks:

Recommended Investigations

Contact with WCB case manager ☐ Yes ☐ No

Contact with WCB Chiro Consultant ☐ Yes ☐ No

Referral to Return to Work provider ☐ Yes ■ No

Treatment Complete? ☐ Yes ☐ No If yes, status/discharge recommendations:

Is this a request for treatment extension beyond the current authorized time frame? ☐ Yes ☐ No If yes, number of weeks of additional therapy required?

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 working or able to perform modified duties, please describe, Please make a selection below as they relate to the injury:

Sitting	☐ Able	☐ Unable	☐ Limited to ____ Hours
Standing	☐ Able	☐ Unable	☐ Limited to ____ Hours
Walking	☐ Able	☐ Unable	☐ Limited to ____ Hours
Bending	☐ Able	☐ Unable	☐ Limited
Twisting	☐ Able	☐ Unable	☐ Limited
Kneeling/squatting	☐ Able	☐ Unable	☐ Limited

Climbing	☐ Able	☐ Unable	☐ Limited
Lifting	☐ Able	☐ Unable	☐ Limited, Max of _____ (lbs/kg)
Pushing / pulling	☐ Able	☐ Unable	☐ Limited
Overhead reaching	☐ Able	☐ Unable	☐ Limited
Driving	☐ Able	☐ Unable	☐ Limited to ____ Hours

Other reasons why the patient cannot work:

☐ Hospitalized ☐ Self reported pain ☐ Opioids/Medication side effects

Other restrictions or additional comments:

Job requirements confirmed by:

☐ 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)

WCB Billing Number: _____

Signature:

Printed Name:

Telephone Number

Fax Number

Provider's Reference Number:

Date: *(Year / Month / Day)*