Workers' Compensation Board – Alberta
Box 2415
Edmonton, AB T5J 2S5
Fax: 780-427-5863 or 1-800-661-1993
contact.centre@wcb.ab.ca

C1517
WORKER POST INJECTION REPORT
PAIN MANAGEMENT & INJECTIONS

WORKER DETAILS

		WCB claim number [
Surname	First name and initial	Date of birth *(yyyy/mm/dd)*
Injection or procedure date (*yyyy/mm/dd)*		Date of accident *(yyyy/mm/dd)*

POST INJECTION OR PROCEDURE QUESTIONS

Please complete this report 3 to 7 days after receiving a pain injection or treatment.

Has there been an overall improvement in your function? ☐ Yes ☐ No

How would you describe your level of function?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Provide your estimate of average pain severity in the last week:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have more injections booked? ☐ Yes ☐ No ☐ N/A

ADDITIONAL INFORMATION

Worker signature

Date *(yyyy/mm/dd)*

Please submit the completed form to contact.centre@wcb.ab.ca