## Physician's Report Completion Guidelines

## WORKERS' COMPENSATION BOARD OF NO

\* Mandaton, Information

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Physician's Report
Form 8/10

General Instructions – Please print clearly in dark blue or black ink. Alternatively, the form can be viewed through Adobe Acrobat, completed electronically (use the tab key to move through each field on the form) and printed. Submit the form by mail or fax to the WCB within 5 business days of the worker's visit. Whenever possible, the worker's claim number should be noted on the form.

* WORKER INFORM	number should be noted on the form.				
Last Name	First Name	Initi	al	Date of Birth  dd mm yyyy	
Street	Worker Information – Provides the identification information for the worker. This helps properly identify the worker and provides important worker and employer contact information.				
Home/Cell Phone	Work Phone E	Employer Name		Worker's Job Title/Occupation	
* INJURY INFORMATION					
Date of Injury:	yyyy Date of Visit:  dd mm yyyy	Diagnosis: (specify body part)			
Subjective Findings:	<i>Injury Information</i> – Reflects the physician's diagnosis and the subjective and objective findings of the worker examination. Subjective findings are those reported by the worker. Objective findings are identified by examining the worker, e.g. range of motion, muscle spasm, neurological findings.				
Objective Findings:					
* RETURN-TO-WORI					
Is the worker still working?					
Return to Work Plan – Identifies the worker's current abilities in relation to work classification, pre-injury work and					
Current Work Capabilit any accommodations needed to help the worker's safe and timely return to work. Definitions of the work capabilities					
(e.g. sedentary, medium, etc.) are found on the back of the form. Ensure you reflect expected return to either pre- injury or transitional work along with a date. Note any pre-existing or current problems/barriers influencing recovery					
Are you aware of any real figure of transitional work along with a date. Note any pre-existing of current problems/barners initidencing recovery (e.g. diabetes, prior injury to same body part, fear or re-injury, etc.).					
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* TREATMENT PLAN					
	Methodology / Goals		<u>Timeframe</u>		
Treatment Plan	consultation with the Medical Di- transitional duties where possible medications (drug name & dosag	sability Advisor (MDA) or surgica e. Treatment goals should relate ge) and/or referrals needed as a re	and goals for any required medical treatment. Timeframes should be made in bility Advisor (MDA) or surgical protocol, if treatment follows surgery. Include Treatment goals should relate to the pre-injury job requirements. Include any and/or referrals needed as a result of the injury. Follow-up plan should outline		
Medications, referrals, tests, Xrays, MRI, etc.	objectives for the next appointment such as to discuss progress on treatment plan or to review diagnostic tests/ referral results (e.g. if the current plan is to provide medication and support light work, the follow-up may be to reevaluate in 2 weeks to assess if the plan is on track and if transitional work can proceed based on functional progress).				
Follow-up Plan					
* PHYSICIAN CERTIFICATION I certify that this is a complete and accurate report; that the fees charged are in accordance with the WCB Contractual Fee Schedule; that I have received no prior payment; and that I have read the reporting responsibilities on the back of this form.					
Physician's Signatur	Physician Certification – Provides physician identification and contact information. Ensure the physician's name is printed clearly along with phone and fax numbers. It also provides the physician's confirmation on the validity of the report information and associated fees.				