WCB, Halifax office
5668 South Street
PO Box 1150, Halifax NS, B3J 2Y2
Tel: 1-800-870-3331 toll free or 902-491-8999 local
Fax: 1-855-723-3975 or locally 902-491-8001

Referral Form for Centralized Surgical Services Program

CLIENT INFORMATION:

Last name:	First Name:	Initial:	**WCB Claim #:**
Address:		Province:	Postal Code:
Gender: ☐ M ☐ F	Health Card #:	Family Physician Name:	
Daytime Phone Number:	Evening Phone Number:	Employer name:	Date of Birth: dd / mm / yyyy

INJURY INFORMATION:

DATE OF INJURY: dd / mm / yyyy **DIAGNOSIS:** _____

MECHANISM OF INJURY: (Details: action, activity, anatomic position, lifting, twisting, force direction and impact, torsion, etc.)

_____

_____

ORTHO ☐ Right ☐ Left ☐ Bilateral

Upper: ☐ Shoulder ☐ Elbow ☐ Hand ☐ Wrist ☐ Carpal Tunnel

Lower: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot

General ☐ Inguinal Hernia ☐ Incisional Hernia ☐ Umbilical Hernia ☐ Other: _____

Spine ☐ Cervical ☐ Thoracic ☐ Lumber

Clinical Findings: ☐ Decreased ROM ☐ Swelling ☐ Weakness/power loss ☐ Neurological Abnormality ☐ Gait Disturbance ☐ Abnormal SLR ☐ Abnormal/absent Reflexes ☐ Sensory Deficit ☐ Bowel/bladder ☐ Other: _____

Height: _____ **Weight:** _____ **Investigations** **Include copy of report** ☐ XRay ☐ CT/MRI ☐ Nerve Conduction Studies ☐ Other

Details: _____

PAST MEDICAL HISTORY:

SURGICAL: _____

_____

MEDICAL: ☐ Diabetes ☐ Heart Disease ☐ Sleep Apnea ☐ COPD ☐ Psychiatric/Addictions ☐ Other: _____

ALLERGIES: _____

MEDICATIONS: *attach list if necessary _____

TREATMENTS already attempted for same injury: _____

If client was referred to surgeon in the past for injury to same body location, please record surgeon's name: _____

REFERRING PHYSICIAN CERTIFICATION:

Signature of Physician: _____ Phone Number: _____

Physician Name: _____ Date: dd / mm / yyyy

Address: _____ WCB Physician # _____

*All additional pages and attachments to this Form must be annotated with the WCB Claim Number