WORK SAFE. FOR LIFE.
WCB OF NOVA SCOTIA

Halifax Office
1-800-870-3331 toll free
902-491-8999 local
902-491-8001 fax

Sydney Office
1-800-880-0003 toll free
902-563-2444 local
902-563-0512 fax

CTS - Physician Hand/Wrist Report

WCB Claim #: _____

Worker Information			
Worker's Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)
Address Street	City/Town	Province	Postal Code
Home/Cell Phone	Work Phone	Date of Injury (dd/mm/yyyy)	Health Card Number:

The following information is required in order to assess the worker's claim regarding hand/wrist symptoms (potential Carpal Tunnel Syndrome or CTS) being causally related to the workplace. This form must be completed, signed and dated by the family doctor. If you have any questions about this form, please contact the WCB of NS.

A. Please describe the symptoms reported by the worker.

B. When were the symptoms first reported by worker?

C. When did you begin treating this worker?

D. Please provide your clinical examination findings:

Finding	Left	Right
Phalens Test		
Reversed Phalens		
Tinel's Sign		
Carpal Compression		
Muscle Wasting		
Sensory Testing		
Other Relevant Findings		

WCB Claim #: _____

E. Please mark the areas where the worker finds the following described sensations. Use the symbols as provided. Mark all affected areas.

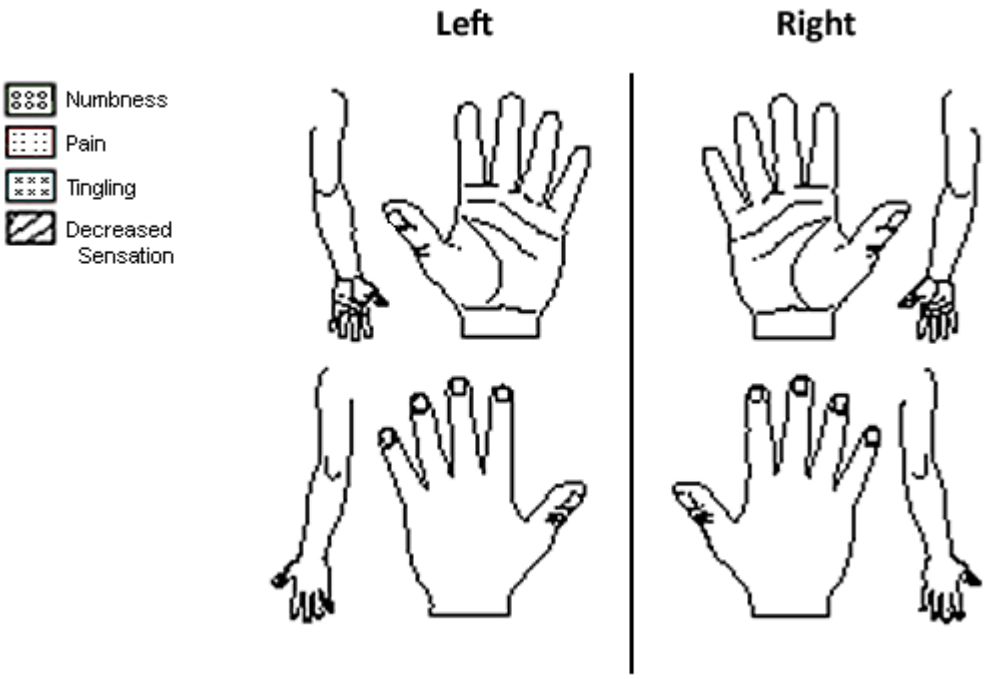

Figure adapted with permission

F. Please provide your diagnosis and or your differential diagnosis:

G: Are you aware of any other conditions or activities which could be impacting this complaint:

H: Other Comments:

I: Does the Worker have:

Condition	Yes	No	Comments
Diabetes			
Thyroid Disorders (Myxedema, etc.)			
Inflammatory Arthritis (RA, Gout)			
Renal Disease			
Hormonal Condition (HRT, Pregnancy, Menopause, etc.)			
Anatomic (Fracture, OA, Acute Trauma, Neoplasia etc)			
Surgical History?			
Acute Limb Trauma			
Cervical Spine Co-Morbidity			

WCB Claim #: _____

J: Please list all medications currently prescribed to the worker :
K: Height: Weight:
L: Please list lab results a. SED rate b. Glucose c. TSH
M: Please attach copies of any electrodiagnostic testing (EMG, NCV, etc.)

Health Care Provider Information (to be completed by health care provider, please print)		
Name of Physician (please print): _____ HS # _____		Date: _____
Signature: _____	Phone: _____	Fax:_____