WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Primary and Emergency Care Report

Information and support for this form
www.wcb.ns.ca/health-services/physicians

To be completed by physicians and nurse practitioners.
Fax completed form to 902-491-8001.

Reset form

WCB CLAIM NUMBER

DATE OF APPOINTMENT
mm/dd/yy

PATIENT (EACH VISIT)			DATE OF BIRTH
Last Name	First Name	Middle Initial	mm/dd/yy
Address Street	City	Province	Postal Code
Home phone	Cell phone	Health Card Number	

INJURY (First visit and when changes occur)		
Job Title/Occupation	Employer	Employer Phone
Injury Type ☐ Psychological injury ☐ Physical injury Date of injury mm/dd/yy mm/dd/yy		Injury Location ☐ Left side ☐ Right Side ☐ N/A
Diagnosis		

Clinical notes (Optional each visit)

Expand on the mechanism of injury with subjective and objective findings. Include indications of pre-existing conditions or barriers to recovery.
Clinical notes should capture findings from the current visit with the patient and include any medical changes since the last visit.

Billing Code WCB26

TREATMENT (First visit and when modified)

☑ Provided in Clinical Notes above

☐ Medications (Review WCB's Special Authorization Criteria)

☐ List names of any referrals requested (submit MRI and surgical referrals directly to WCB)

RETURN TO WORK (Each visit if changed)

Are there any medical barriers, restrictions, or limitations to returning to work?

☐ Yes ☐ No

If yes, please expand:

☐ Provided in Clinical Notes above

MESSAGE TO WCB (Optional each visit)

☐ I would like to speak to a WCB representative. Please contact me at (the best phone number to reach me) to discuss this case.

ATTENDING PRACTITIONER 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.

Signature	CPSNS/NSCN
Name	Phone
Date mm/dd/yy	Address