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Direct Access to **Tier One Services**

A Tiered Service Provider's Guide

to Forms and Reporting

WHEN A WORKER IS INJURED AT WORK, helping them get back to work as soon as it is safe is an important part of injury recovery. Direct access to tier one services, such as a physiotherapist or chiropractor, gives workers who have experienced a strain or sprain injury more timely access to the health care services they need, allowing the return-to-work process to begin right away.

As a primary health care professional, you play a key role in the early assessment of sprain and strain injuries, diagnosis and, if necessary, treatment. Working with the injured worker, employer, WCB case worker, the worker's doctor and other health care providers, you help ensure a worker's safe return to work, to their regular job or to transitional duties. This is good for the worker and their family, and helps provide Nova Scotia with a healthier workforce.

A Tiered Service Provider's Guide to Forms and Reporting provides information on the WCB's Direct Access to Tier One Services process, and some of the Tier 1 forms you need to complete. It is important to also keep in touch with the WCB case worker – they are knowledgeable on the workers' compensation system and can help guide you through our return-to-work process.

Contents

How it Works

A worker who has experienced a sprain or strain injury at work is sent to you for an assessment. This assessment will occur within 72 hours (three days) of the injury. Ideally, it will happen on the same day. The worker's employer may complete the first two sections of the **Intake Report – Form A** and send it to you, or the worker will bring the form with them for you to complete. You may also complete and submit a Form A if no claim is established yet for this worker.

Talk to the worker about their injury, diagnosis and, if required, a treatment plan. You should also explain to them what to expect during and after treatment.

Have the worker sign a **Release of Information Form**, allowing you to share certain information with the worker's employer.

Contact the worker's employer for additional information, including the worker's job description, the functional demands of their job and what transitional duties are available if appropriate.

If what the worker can safely do matches the demands of their regular work, the worker can return to their job right away. Fill out and submit the **Initial Assessment – Form B**. Please note this form must be submitted to the WCB within five days of the worker's initial assessment. The WCB case worker will contact you, to let you know if the treatment plan is approved.

If the worker is unable to return to their regular job right away, you also need to submit a **Physical Abilities Report – Form E**. It should accompany Form B.

Perform a physical abilities assessment, explaining to the worker this is a series of activities that allows you to find out what job tasks – lifting, carrying, walking, etc. – they can safely perform. The focus of this evaluation is to assess the injury and determine the worker's capacity for returning to work, either to their regular job or to transitional duties.

Work in collaboration with the employer, the worker, the worker's doctor and other health care providers to help the WCB case worker develop an appropriate return-to-work plan, including what transitional duties, if any, can be provided.

If on assessment you suspect the injury is more serious than a sprain or strain, send the worker to their doctor or hospital and provide assistance, as necessary, to ensure their well-being.

Reporting Fees & Submission of Forms

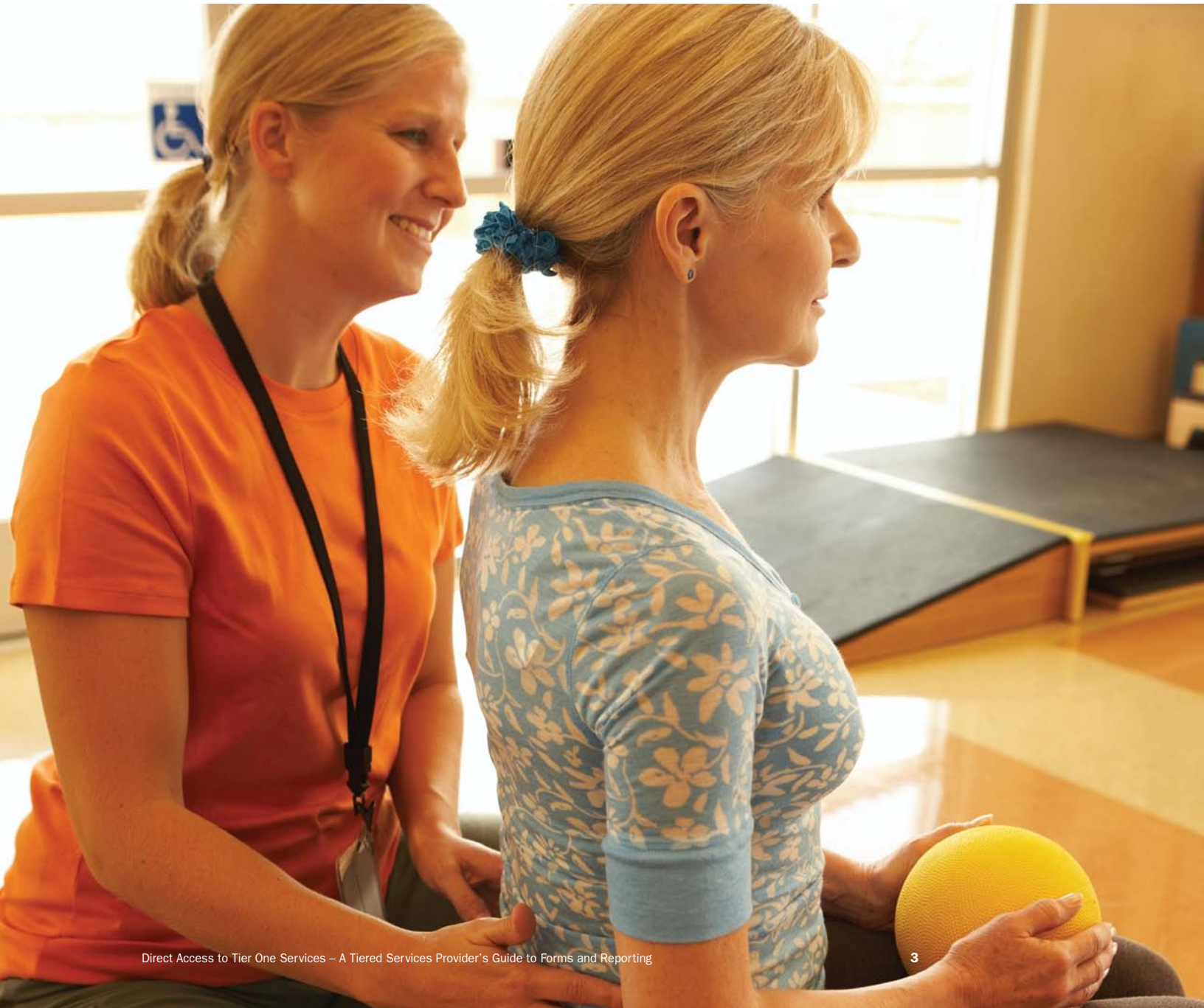
Submitted forms are to be completed in full with copies only going to those who are noted on the bottom of each form. Incomplete or illegible reports may be returned, unpaid. For Fee Schedule information and details regarding contractual obligations, please refer to your contract and service guide.

Please ensure forms are:

- Legible – type or print clearly

- Received within the following time frames:
  - Form A within three business days of intake
  - Form B & E within five business days of initial assessment

All forms are to be faxed to **902-491-8001** (Mainland NS), **902-563-0512** (Cape Breton) or toll-free **1-855-723-3975**.

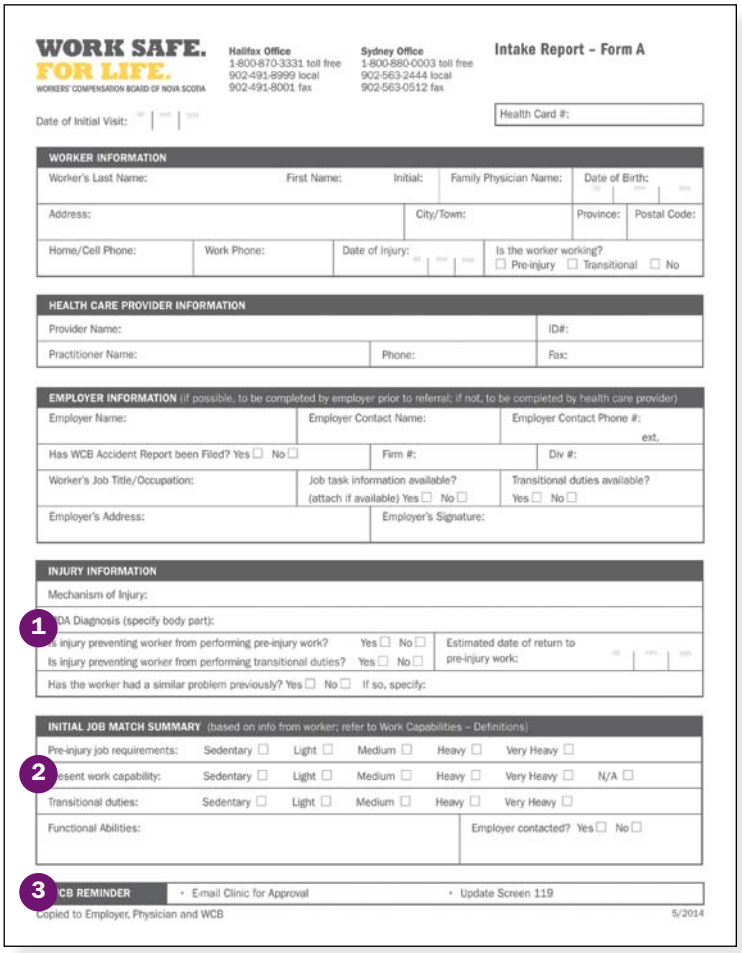


Intake Report – Form A

The worker's employer may complete the first two sections of the **Intake Report – Form A** and send it to you, or the worker may bring it with them for you to complete. Be sure to call the WCB to determine if a claim exists prior to completing the form.

Once completed, this form is sent to the worker's employer, doctor and to the WCB.

If the worker has an existing WCB claim, for this injury, submit an **Initial Assessment – Form B** (no Form A required).



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902-491-8999 local
902-491-8001 fax

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

Intake Report – Form A

Date of Initial Visit:

Health Card #:

WORKER INFORMATION

Worker's Last Name: | First Name: | Initial: | Family Physician Name: | Date of Birth:

Address: | City/Town: | Province: | Postal Code:

Home/Cell Phone: | Work Phone: | Date of Injury: | Is the worker working? ☐ Pre-injury ☐ Transitional ☐ No

HEALTH CARE PROVIDER INFORMATION

Provider Name: | ID#:

Practitioner Name: | Phone: | Fax:

EMPLOYER INFORMATION (if possible, to be completed by employer prior to referral; if not, to be completed by health care provider)

Employer Name: | Employer Contact Name: | Employer Contact Phone #: ext.

Has WCB Accident Report been Filed? Yes ☐ No ☐ | Firm #: | Div #:

Worker's Job Title/Occupation: | Job task information available? (attach if available) Yes ☐ No ☐ | Transitional duties available? Yes ☐ No ☐

Employer's Address: | Employer's Signature:

INJURY INFORMATION

Mechanism of Injury:

DA Diagnosis (specify body part):

s injury preventing worker from performing pre-injury work? Yes ☐ No ☐ | Estimated date of return to pre-injury work:

Is injury preventing worker from performing transitional duties? Yes ☐ No ☐

Has the worker had a similar problem previously? Yes ☐ No ☐ If so, specify:

INITIAL JOB MATCH SUMMARY (based on info from worker; refer to Work Capabilities – Definitions)

Pre-injury job requirements: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐

esent work capability: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐ N/A ☐

Transitional duties: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐

Functional Abilities: | Employer contacted? Yes ☐ No ☐

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1. This section provides information about the worker's injury that will help in the development of an appropriate return-to-work plan. This includes the MDA diagnosis based on the initial assessment, including the worker's ability to perform regular or transitional duties.
   - The mechanism of injury should be a brief description of how the worker sustained the injury, and if the injury occurred with a single event (e.g., trip) or over a period of time.
   - The estimated date of return to pre-injury work is based on the initial assessment and the Medical Disability Advisor (MDA) diagnosis.

2. This section helps the worker's employer and the WCB identify the worker's current abilities. Information on the five work classifications can be found at this link – Work Capabilities Definitions
   - Indicate the worker's regular (pre-injury) work classification and determine their current abilities in relation to work classification.
   - Functional abilities is a description of what the worker can safely do – walk, sit, lift up to # kilograms, etc.
   - Confirm that you have been in contact with the worker's employer. It is important to contact the employer to confirm the worker's job duties and classification, and determine if transitional duties matching the worker's abilities are available.

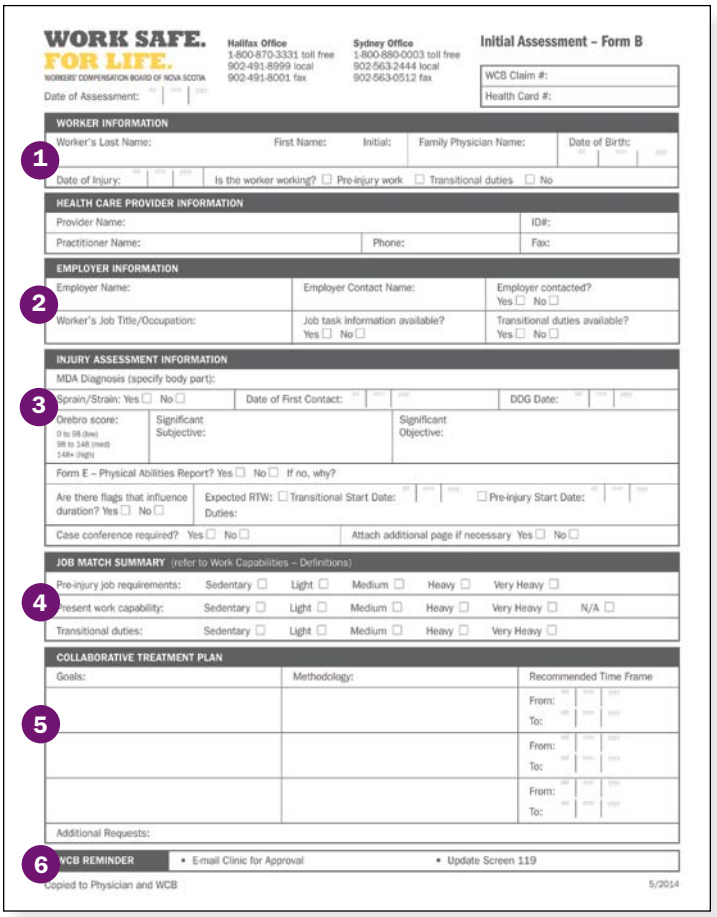
3. If the claim is/is not approved, the WCB will contact you via e-mail.

Initial Assessment – Form B

The **Initial Assessment – Form B** is submitted following the initial assessment and details the worker's injury, diagnosis and, if appropriate, a treatment plan. It contains some of the same information found on Form A, but includes more detail on the worker's injury, including the musculoskeletal examination.

Form B must be submitted within five days of the worker's initial assessment. It is sent to the worker's doctor and to the WCB. It is not sent to the employer.

If the worker is unable to return to their regular job right away, you must also submit a **Physical Abilities Report – Form E** with the Form B. The Form E (without Form B) must also be sent to the employer. Refer to page 7 of this guide for more information about the Form E.



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Initial Assessment – Form B

Date of Assessment:
WCB Claim #:
Health Card #:

WORKER INFORMATION
Worker's Last Name: | First Name: | Initial: | Family Physician Name: | Date of Birth:
Date of Injury: | Is the worker working? ☐ Pre-injury work ☐ Transitional duties ☐ No

HEALTH CARE PROVIDER INFORMATION
Provider Name: | ID#:
Practitioner Name: | Phone: | Fax:

EMPLOYER INFORMATION
Employer Name: | Employer Contact Name: | Employer contacted? Yes ☐ No ☐
Worker's Job Title/Occupation: | Job task information available? Yes ☐ No ☐ | Transitional duties available? Yes ☐ No ☐

INJURY ASSESSMENT INFORMATION
MDA Diagnosis (specify body part):
Sprain/Strain: Yes ☐ No ☐ | Date of First Contact: | DDG Date:
Orebro score: 0 to 95 (low) 96 to 148 (med) 149+ (high) | Significant Subjective: | Significant Objective:
Form E – Physical Abilities Report? Yes ☐ No ☐ If no, why?
Are there flags that influence duration? Yes ☐ No ☐ | Expected RTW: ☐ Transitional Start Date: ☐ Pre-injury Start Date: | Duties:
Case conference required? Yes ☐ No ☐ | Attach additional page if necessary Yes ☐ No ☐

JOB MATCH SUMMARY (refer to Work Capabilities – Definitions)
Pre-injury job requirements: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐
Present work capability: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐ N/A ☐
Transitional duties: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐

COLLABORATIVE TREATMENT PLAN
Goals: | Methodology: | Recommended Time Frame
From: / To:
From: / To:
From: / To:
Additional Requests:

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1. This information is used to properly identify the worker. Indicating if the worker is working is important in planning return to work appropriate to the worker's abilities and job duties. Be sure to note if the worker is working reduced hours.

2. It is important to contact the worker's employer to gather information about the worker, including job description, functional job demands and if transitional duties matching the worker's abilities are available. This will help in the development of the return-to-work plan. If the worker requires surgery, you still need to contact the employer as transitional duties may still be appropriate.

3. This section details the significant objective and subjective findings of the worker's musculoskeletal examination (part of the initial assessment). The diagnosis should be in keeping with the MDA diagnosis.
   - Confirm if the **Physical Abilities Report – Form E** is attached and, if not, the reason why. Include any flags that could influence the worker's capacity for returning to work.
   - The Orebro score must be included if the worker is not expected to return to full pre-injury duties within two weeks from the date of injury.
   - The expected return-to-work date is the date the worker is expected to return to their pre-injury job or to transitional duties.
   - If additional space is needed on Form B, the Additional Information form should be attached with the associated check box marked accordingly.

4. This section identifies the worker's regular work classification and determines their current abilities in relation to work classification. Information on the five work classifications can be found at this link – Work Capabilities Definitions.

5. If tier one treatment is appropriate, the Collaborative Treatment Plan outlines the treatment plan and goals. The goals relate to the worker's pre-injury job requirements, while the treatment plan includes and supports transitional duties if they are available, based on information provided by both the employer and the worker. The treatment plan's time frame and goals are made in consultation with the MDA or surgical protocol if treatment follows surgery. Additional requests should also be made in this section.

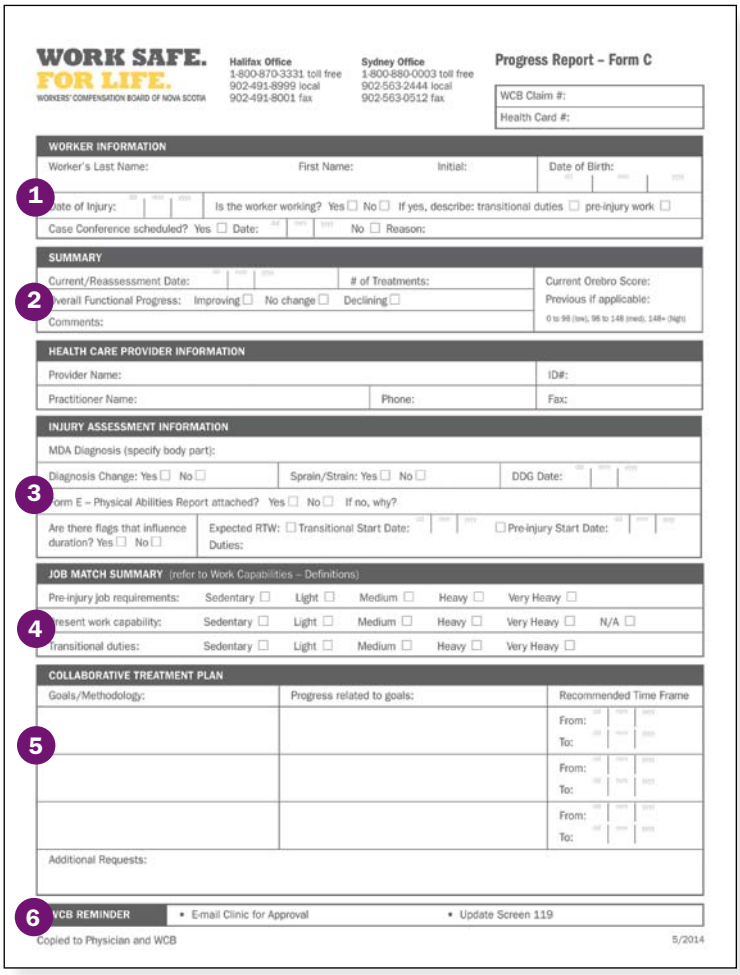
6. If the treatment plan is/is not approved, the WCB case worker will contact you via e-mail.

Progress Report – Form C

The **Progress Report – Form C** is used to update the worker's progress, including treatment plan and goals. This report is submitted to the WCB case worker and the worker's doctor every two weeks until the treatment plan is completed. The first progress report is an important time to re-evaluate the worker's progress and consider triaging to another service tier or alternate treatment, if appropriate.

If the worker is expected to return to work in the next two weeks, submit Form C only. If the worker is not expected to return to work in the next two weeks, submit both Form C and **Physical Abilities Report – Form E**. The Form E (without Form C) must also be sent to the employer. Refer to page 7 of this guide for more information about the Form E.

This report is sent to the WCB case worker and to the worker's doctor. **Form C is not sent to the employer.**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Progress Report – Form C

WCB Claim #:
Health Card #:

WORKER INFORMATION
Worker's Last Name: First Name: Initial: Date of Birth:
Date of Injury: Is the worker working? Yes ☐ No ☐ If yes, describe: transitional duties ☐ pre-injury work ☐
Case Conference scheduled? Yes ☐ Date: No ☐ Reason:

SUMMARY
Current/Reassessment Date: # of Treatments: Current Orebro Score:
Overall Functional Progress: Improving ☐ No change ☐ Declining ☐ Previous if applicable:
Comments: 0 to 98 (low), 99 to 148 (med), 148+ (high)

HEALTH CARE PROVIDER INFORMATION
Provider Name: ID#:
Practitioner Name: Phone: Fax:

INJURY ASSESSMENT INFORMATION
MDA Diagnosis (specify body part):
Diagnosis Change: Yes ☐ No ☐ Sprain/Strain: Yes ☐ No ☐ DDG Date:
Form E – Physical Abilities Report attached? Yes ☐ No ☐ If no, why?
Are there flags that influence duration? Yes ☐ No ☐ Expected RTW: ☐ Transitional Start Date: ☐ Pre-injury Start Date: Duties:

JOB MATCH SUMMARY (refer to Work Capabilities – Definitions)
Pre-injury job requirements: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐
Present work capability: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐ N/A ☐
Transitional duties: Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy ☐

COLLABORATIVE TREATMENT PLAN
Goals/Methodology: | Progress related to goals: | Recommended Time Frame
From: To:
From: To:
From: To:
Additional Requests:

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1. This information is used to properly identify the worker.
   - Indicating if the worker is working is important in planning return to work appropriate to the worker's abilities and job duties. Be sure to note if the worker is working reduced hours.
   - The WCB case worker will schedule a case conference to discuss the worker's return-to-work plan. This case conference will include you, the WCB case worker, the worker and the worker's employer. The worker's doctor will also be consulted and should participate in the case conference, if possible. Please note you are required under contract to attend the mandatory four-week case conference.

2. This is a summary section and includes the date of re-assessment, number of treatments, comparison of Orebro scores and the overall functional progress of the worker.

3. This section confirms your diagnosis or updated diagnosis (in keeping with the MDA) and whether it is a sprain/strain. Include any flags that could influence the return-to-work plan.

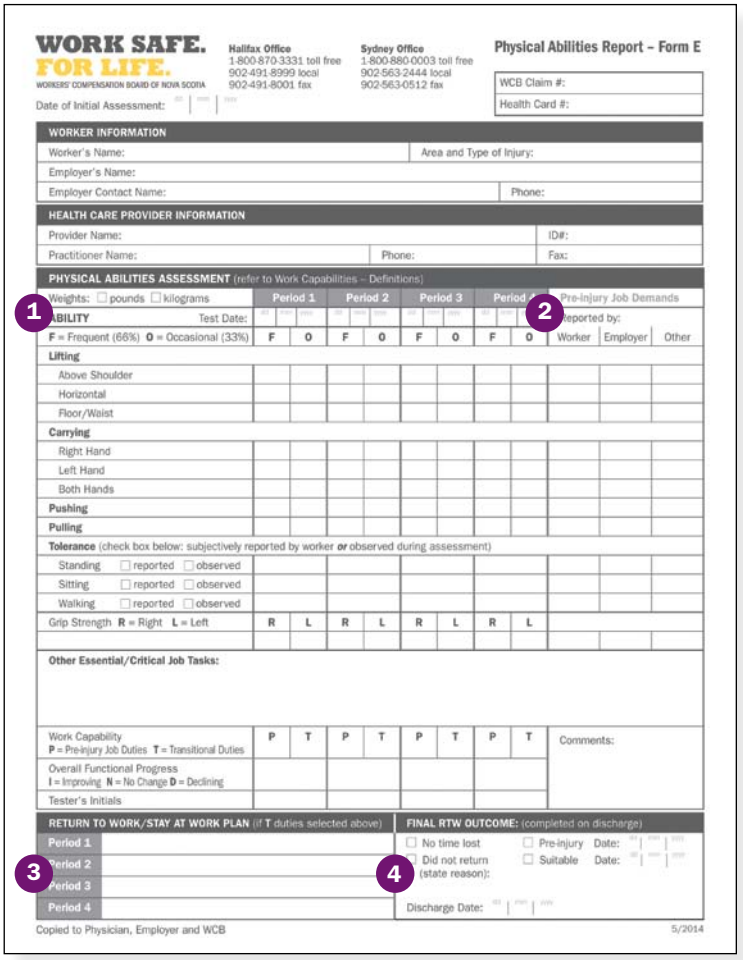
4. This section identifies the worker's regular (pre-injury) work classification and describes their current abilities in relation to work classification. Information on the five work classifications can be found at this link – Work Capabilities Definitions.

5. Updates or changes in the original or previously approved treatment plan, goals, progress to date and timeline are documented in the Collaborative Treatment Plan. An updated plan is based on a discussion or case conference with the WCB case worker, the worker, and the worker's employer. The worker's doctor will also be consulted, if possible. Requests for orthotics, bracing or other equipment should be noted in the Additional Requests section.

6. If the treatment plan is/is not approved, the WCB case worker will contact you via email.

Physical Abilities Report – Form E

The **Physical Abilities report – Form E** is completed when a worker is assessed as not being able to return to their regular job within two weeks from injury date. It allows the practitioner to monitor continued improvement in functional progress or if there is no or minimal improvement contact the WCB case worker regarding a case conference to discuss the need for an alternate treatment plan. It tracks a worker's functional progress and ensures the return-to-work plan continues to include appropriate transitional duties based on the worker's improving abilities. Form E can also be used to help the worker see the ongoing and positive improvement in their functional abilities.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Physical Abilities Report – Form E

WCB Claim #:
Health Card #:

Date of Initial Assessment:

WORKER INFORMATION
Worker's Name:
Area and Type of Injury:
Employer's Name:
Employer Contact Name:
Phone:

HEALTH CARE PROVIDER INFORMATION
Provider Name:
ID#:
Practitioner Name:
Phone:
Fax:

PHYSICAL ABILITIES ASSESSMENT (refer to Work Capabilities – Definitions)
Weights: pounds kilograms

ABILITY Test Date:	Period 1		Period 2		Period 3		Period 4		Pre-Injury Job Demands reported by:		
F = Frequent (66%) O = Occasional (33%)	F	O	F	O	F	O	F	O	Worker	Employer	Other
Lifting											
Above Shoulder											
Horizontal											
Floor/Waist											
Carrying											
Right Hand											
Left Hand											
Both Hands											
Pushing											
Pulling											
Tolerance (check box below: subjectively reported by worker *or* observed during assessment)											
Standing reported observed											
Sitting reported observed											
Walking reported observed											
Grip Strength R = Right L = Left	R	L	R	L	R	L	R	L			

Other Essential/Critical Job Tasks:

	P	T	P	T	P	T	P	T	Comments:
Work Capability P = Pre-injury Job Duties T = Transitional Duties									
Overall Functional Progress I = Improving N = No Change D = Declining									
Tester's Initials									

RETURN TO WORK/STAY AT WORK PLAN (if T duties selected above)
Period 1
Period 2
Period 3
Period 4

FINAL RTW OUTCOME: (completed on discharge)
No time lost Pre-injury Date:
Did not return Suitable Date:
(state reason):
Discharge Date:

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1. This section records functional testing results. Explanations of the ability levels – frequent (F) and occasional (O) – can be found at this link – Work Capabilities Definitions. All necessary job tasks are to be tested for function, including repetitive tasks. Repetitive job tasks can be recorded in the "Other Essential/Critical Job Tasks" section. Each column shows the results for the date tested, tester's initials and overall functional progress. Upon comparison, if no improvement is demonstrated, the treatment plan should be reconsidered.
   - When using pounds or kilograms, the same type of measurement should be used for both tested abilities and job demands.

2. For the initial assessment, Job Demands can initially be provided by the worker or through a generic job description found under the National Occupational Classification (NOC) but need to be confirmed by the employer (See Forms A & B).
   - If the employer is unable to confirm the worker's job demands, the WCB case worker will follow-up with the employer and, if necessary, arrange for a job-site analysis.
   - If the worker's regular job does not include a component of the functional tasks listed (e.g., lifting above shoulder), mark "N/A" beside that task.
   - Overall functional progress should be included to determine if the worker is improving in each ability category along with the tester's initials for that period.

3. Return to Work/Stay at Work Plan – This section will help determine if the worker is making progress towards achieving their goal of RTW (transitional or pre-injury), or pre-injury job demands.

4. Final RTW Outcome – This shows the date(s) the worker returned to transitional and regular duties. For example, the worker may have returned to transitional duties during the treatment plan and is now, at discharge, returning to regular duties. Final Return to Work Outcome indicates the worker's ability to return to work at the time they are discharged from treatment. For example, if the worker is capable of returning to regular work but doesn't due to seasonal layoff, indicate "able" next to "return to pre-injury work" and provide the reason in the "did not return to work" section. If a worker is functionally capable of pre-injury work at time of discharge but does not return, explain why.

If you do not feel an assessment is appropriate or it is unsafe for the worker to participate, send the worker to their doctor or hospital and provide assistance, as necessary, to ensure their well-being. Schedule a follow-up appointment with the worker to perform the assessment.

It may be appropriate to delay the physical abilities assessment when:

- Too soon post-surgery (as per surgery protocol)
- Medical instability (e.g., during assessment, joint is found to be unstable)
- Surgical site is unstable (range of motion causes stress on stitches or leaking of surgical repair)
- Unrelated medical condition (e.g., pending hernia repair)
- Pregnancy (precautionary – may include high blood pressure/previous C-section)
- Cardiac instability (precautionary – check with doctor)
- Following cast removal (depending on the status of the fracture)

Form E, along with the **Initial Assessment – Form B**, is submitted to the WCB case worker and the worker's doctor, within five days of the worker's initial assessment if the worker is unable to return to work within two weeks. The Form E (without Form B) must also be sent to the employer.

Form E is updated every two weeks, during treatment, and submitted with the **Progress Report – Form C**. It is sent to the WCB case worker and the worker's doctor. Form E (without Form C) must also sent to the worker's employer.

Additional Information

Use this form if there is insufficient space on Form A, B, C, E, or if additional information has been requested by the WCB case worker.

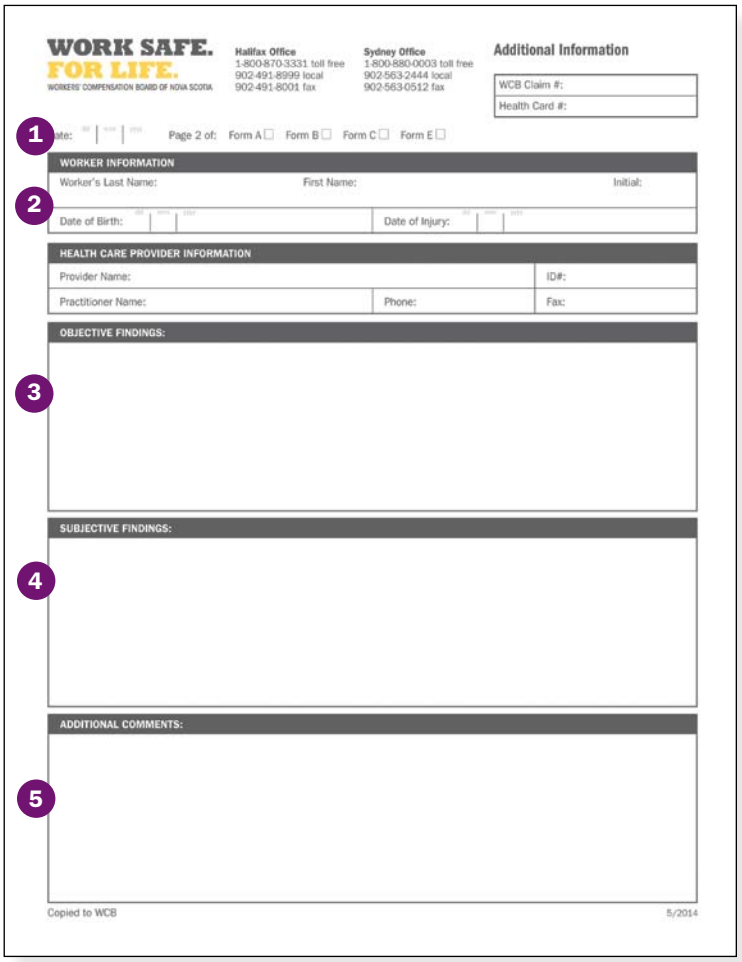
1. The date should match the date of any accompanying form(s).

2. This information is used to confirm the identity of the worker. Please complete all fields in this section.

3. Objective findings relate to actual findings on the musculoskeletal examination, including range of motion, straight leg raising, and reflex testing, as well as any other tests performed during the examination.

4. Include all subjective concerns expressed by the worker relating to their injury. This may include references to sleep disturbance, difficulty performing daily activities, reports of soreness, etc.

5. Include any information you feel may be relevant to the worker's injury and/or expected recovery.



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Additional Information

WCB Claim #:
Health Card #:

1 Date: Page 2 of: Form A ☐ Form B ☐ Form C ☐ Form E ☐

WORKER INFORMATION

2 Worker's Last Name: First Name: Initial:
Date of Birth: Date of Injury:

HEALTH CARE PROVIDER INFORMATION

Provider Name: ID#:
Practitioner Name: Phone: Fax:

OBJECTIVE FINDINGS:

3

SUBJECTIVE FINDINGS:

4

ADDITIONAL COMMENTS:

5

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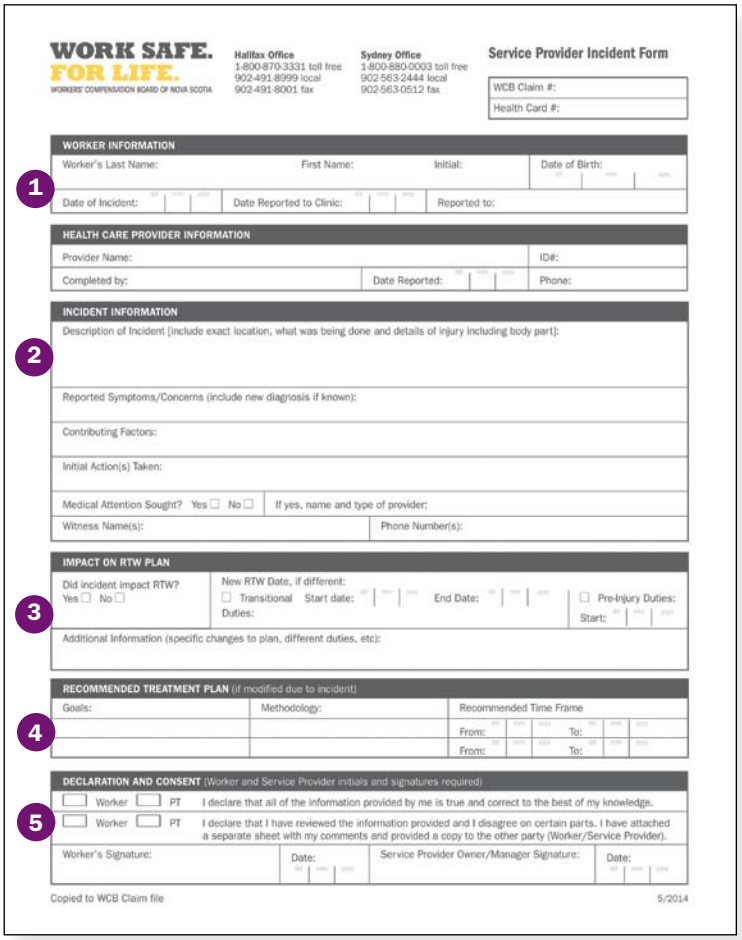
Service Provider Incident Form

The **Service Provider Incident Form** is used to document any incident involving a worker on or within the clinic premises. This information helps the WCB to effectively manage the claim and begin an investigation. Please note, reporting and investigation of an incident will be conducted whether or not medical treatment is required.

This form is sent to the WCB. It should be submitted within 48 hours of the incident.



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Service Provider Incident Form

WCB Claim #:
Health Card #:

WORKER INFORMATION

Worker's Last Name: | First Name: | Initial: | Date of Birth:
Date of Incident: | Date Reported to Clinic: | Reported to:

HEALTH CARE PROVIDER INFORMATION

Provider Name: | ID#:
Completed by: | Date Reported: | Phone:

INCIDENT INFORMATION

Description of Incident (include exact location, what was being done and details of injury including body part):
Reported Symptoms/Concerns (include new diagnosis if known):
Contributing Factors:
Initial Action(s) Taken:
Medical Attention Sought? Yes ☐ No ☐ | If yes, name and type of provider:
Witness Name(s): | Phone Number(s):

IMPACT ON RTW PLAN

Did incident impact RTW? Yes ☐ No ☐ | New RTW Date, if different: ☐ Transitional Duties: Start date: End Date: ☐ Pre-Injury Duties: Start:
Additional Information (specific changes to plan, different duties, etc):

RECOMMENDED TREATMENT PLAN (if modified due to incident)

Goals: | Methodology: | Recommended Time Frame From: To: From: To:

DECLARATION AND CONSENT (Worker and Service Provider initials and signatures required)

☐ Worker ☐ PT I declare that all of the information provided by me is true and correct to the best of my knowledge.
☐ Worker ☐ PT I declare that I have reviewed the information provided and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the other party (Worker/Service Provider).

Worker's Signature: | Date: | Service Provider Owner/Manager Signature: | Date:

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1. This information is used to properly identify the worker, and to help the WCB to effectively manage the claim.

2. This section provides details on the incident. This will help the WCB case worker address any impact to the return-to-work plan.
   - The description should speak to whether the injury is consistent with the mechanism of injury and not to causation. Detail any and all weights, distances, movements and equipment involved and the conditions or activity at the time of the incident. The diagnosis should be in keeping with the MDA diagnosis.
   - Provide details on what may have contributed to the event, and any actions that have been taken to address these factors, if possible.
   - It is important to note if medical treatment was sought, and if anyone witnessed this event.

3. Document any changes to the original treatment plan. An updated plan is based on a discussion or case conference with the WCB case worker, the worker, the worker's employer and doctor.

4. This section details treatments goals, chosen methodologies and timelines. If further treatment is required, indicate how many treatments have been provided to date. Requests for orthotics, bracing or other equipment should be noted here.

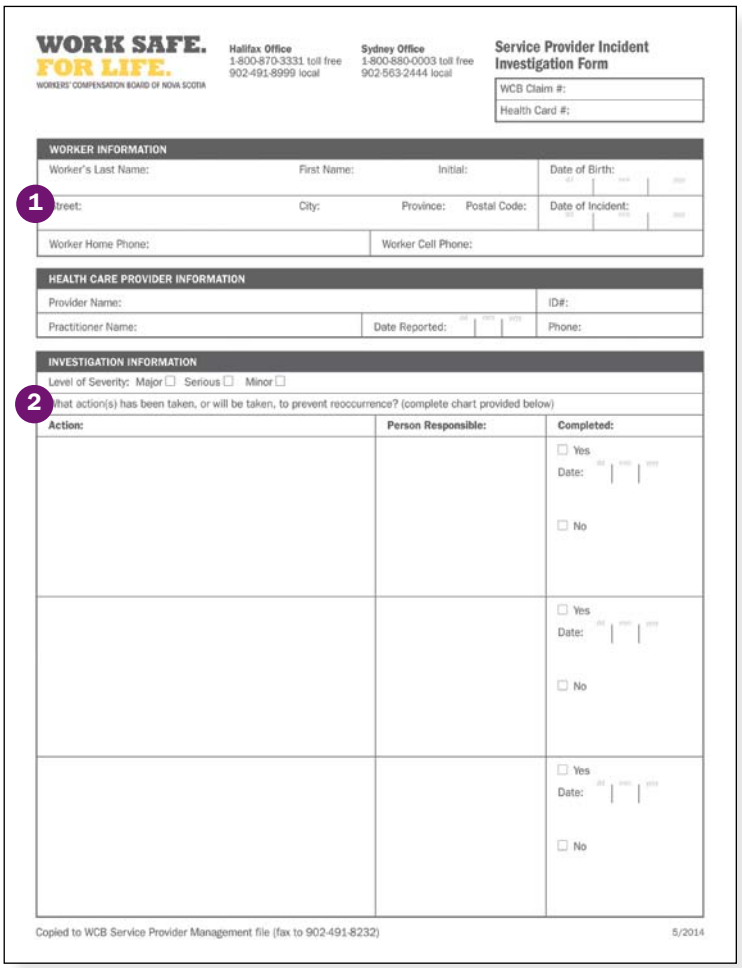
5. The Declaration and Consent section has four purposes: to show completion by the worker and clinic owner/manager; to provide an opportunity for the parties to disagree; to provide consent; and to inform the parties of the WCB's right to obtain from and share information with relevant parties.

Service Provider Incident Investigation Form

The **Service Provider Incident Investigation Form** is submitted within five days of the incident. Fax this form directly to the Coordinator, Service Provider Relationships at (902) 491-8232. It should include recommendations on how to prevent the documented incident from occurring again. Please note, reporting and investigation of an incident will be conducted whether or not medical treatment is required.

1. This information is used to properly identify the worker in relation to the investigation process.

2. This information is used by the WCB in its investigation.
   - There are three categories of injury severity: Major – resulting in death or permanent disability, this must be reported to the Department of Labour; Serious – resulting in lost time from work due to temporary disability and requires medical attention; and Minor – resulting in no physical injury or a physical injury that requires first aid only.
   - Detail all actions the clinic has taken to prevent a reoccurrence of the incident. Include the person responsible for this action(s) and the date(s) completed.



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

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

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

Service Provider Incident Investigation Form

WCB Claim #:
Health Card #:

WORKER INFORMATION

Worker's Last Name: | First Name: | Initial: | Date of Birth:
Street: | City: | Province: | Postal Code: | Date of Incident:
Worker Home Phone: | Worker Cell Phone:

HEALTH CARE PROVIDER INFORMATION

Provider Name: | ID#:
Practitioner Name: | Date Reported: | Phone:

INVESTIGATION INFORMATION

Level of Severity: Major ☐ Serious ☐ Minor ☐

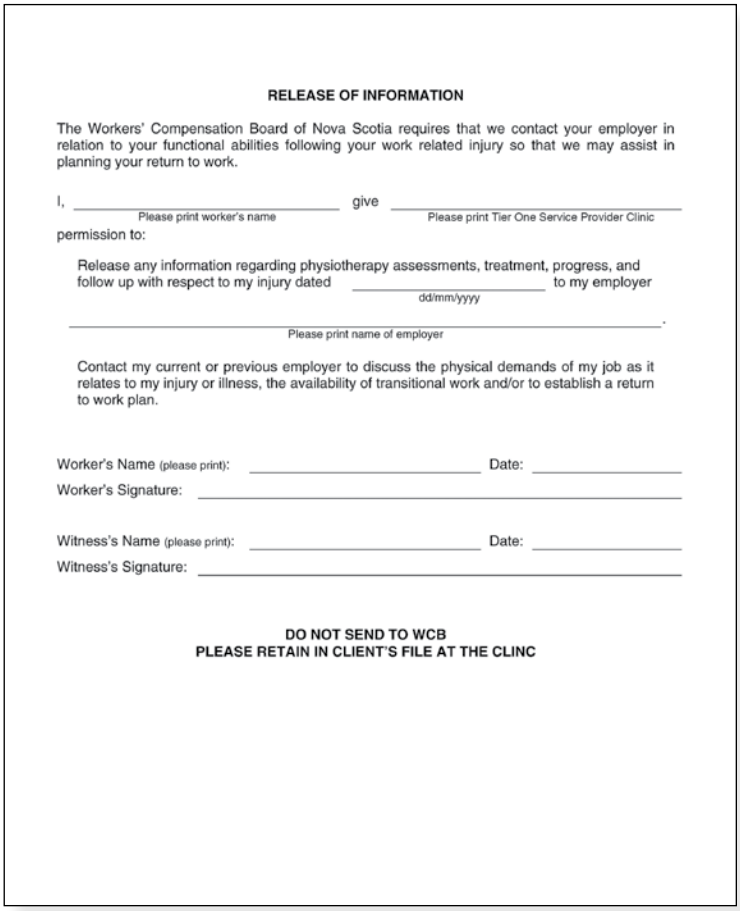
What action(s) has been taken, or will be taken, to prevent reoccurrence? (complete chart provided below)

Action:	Person Responsible:	Completed:
		☐ Yes Date: ☐ No
		☐ Yes Date: ☐ No
		☐ Yes Date: ☐ No

Copied to WCB Service Provider Management file (fax to 902-491-8232) 5/2014

Release of Information

Use this form to obtain the worker's permission to share information with their employer necessary for return-to-work planning. If the worker refuses to sign this release, contact the WCB case worker immediately. The signed release should be kept in the worker's file at the clinic. Do not send it to the WCB. You can also use your own release form.



RELEASE OF INFORMATION

The Workers' Compensation Board of Nova Scotia requires that we contact your employer in relation to your functional abilities following your work related injury so that we may assist in planning your return to work.

I, _____ give _____
Please print worker's name — Please print Tier One Service Provider Clinic

permission to:

Release any information regarding physiotherapy assessments, treatment, progress, and follow up with respect to my injury dated _____ to my employer
dd/mm/yyyy

_____.
Please print name of employer

Contact my current or previous employer to discuss the physical demands of my job as it relates to my injury or illness, the availability of transitional work and/or to establish a return to work plan.

Worker's Name (please print): _____ Date: _____

Worker's Signature: _____

Witness's Name (please print): _____ Date: _____

Witness's Signature: _____

DO NOT SEND TO WCB
PLEASE RETAIN IN CLIENT'S FILE AT THE CLINC

Service Provider Account

Use this form for the billing of all services. Only those services approved by the WCB case worker should be submitted for payment. All forms are to be faxed to **902-491-8001** (Mainland NS), **902-563-0512** (Cape Breton) or toll-free **1-855-723-3975**.

1 Complete all fields in this section. Total treatments to date includes all treatments up to and including those being billed in the current invoice. You cannot bill in advance for treatments.

2 Indicate service provider name (who is the contract signatory) and location (if multiple clinics) in the "Name and Address of Service Provider" field. The treating practitioner's name goes in the "Clinic Contact Name" field. The ID # identifies who the WCB will pay and should be 3 characters (i.e. PHC, CHI, etc.) followed by 3 or 4 numbers. Ensure all mandatory information is provided to avoid delay in payment or a returned invoice. Although invoice numbers are required, do not attach clinic invoices.

3 Indicate what service was provided, next to the corresponding date and in the applicable column (Form B, C, E, Reg Tx, etc.). Only reference services provided for a given month. Use a separate invoice for different months.

4 This includes items, such as braces, orthotics or any other item provided to the worker by the clinic. Only include items that have been pre-approved by the WCB case worker. Provide the service or name of the item next to the corresponding date.

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WORKERS' COMPENSATION BOARD 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

Service Provider Account

WCB Claim #:
Health Card #:

WORKER INFORMATION (Please type or print clearly, and return completed form to the WCB)

Worker's Name: | Address: | Employer:

Date of Birth: | Date of Injury: | Injury/Body Part: | Date of First Treatment: | Total Treatments to Date: | Final Discharge Date:

HEALTH CARE PROVIDER INFORMATION (mandatory)

Name and Address of Service Provider: | Clinic Contact Name:

☐ Own patient ☐ 2nd opinion | ID#: | Invoice date: | Invoice #:

BILLING INFORMATION Please complete the following:

Month	Form A	Form C	Form E	Initial Assess.	Initial Assess. Pkg.*	Reg. Tx	Case Conf.	Job Site Analysis	Job Site Visit	Travel	In-home Tx	Cost ($)	HST
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
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25													
26													
27													
28													
29													
30													
31													
Subtotal	A C E												

TOTAL:

*Initial Assessment package includes call to employer and Orebro.

5/2014

Frequently Asked Questions

Am I allowed to establish a working relationship with an employer?
That's up to you. An employer may ask to establish a working relationship with you as part of their return-to-work program.

Who determines the return-to-work plan?
The WCB case worker will work together with the employer, the worker and you to help determine the return-to-work plan, including transitional duties. The worker's doctor should also be involved.

What if the worker's doctor disagrees with the diagnosis and treatment plan?
Every situation is different. Contact the WCB case worker if there is any disagreement over the diagnosis or treatment plan.

What are transitional duties?
Transitional duties should be as close to the worker's regular work as possible. They may include the modification of some of the worker's regular work duties, the elimination of some duties, some new duties, or a combination of their regular work and any of these transitional duties. Refer to Work Capabilities Definitions in the Service Provider section at www.wcb.ns.ca.

Where do I find the forms I need to fill out?
Forms and information related to Direct Access to Tier One Services are available on our website, at www.wcb.ns.ca/directaccess.

Where do I find fee reporting information?
For Fee Schedule information, refer to your contract.

What if I have questions or require more information?
Visit our website, www.wcb.ns.ca/directaccess, or call 1-800-870-3331 to speak to the WCB case worker.

Contact Information

Halifax Office
PO Box 1150
5668 South Street
Halifax, NS B3J 2Y2
Tel: 902.491.8999
Toll free: 1.800.870.3331
General fax: 902.491.8001

Sydney Office
404 Charlotte Street, Suite 200
Sydney, NS B1P 1E2
Fax: 902.563.0512

Email:
info@wcb.gov.ns.ca

Corporate site:
www.wcb.ns.ca/directaccess

Interactive prevention and return-to-work information:
www.worksafeforlife.ca

Last updated 10/14