

This form is for out-of-province providers to complete. Please fax or mail the completed form to us using the information on the form.

Date of Assessment: dd | mm | yyyy

WCB Claim #:

Health Card #:

WORKER INFORMATION

Worker's Last Name:	First Name:	Initial:	Family Physician Name:	Date of Birth: dd mm yyyy
Date of Injury: dd mm yyyy	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: dd mm yyyy	DDG Date: dd mm yyyy	
Orebro score: 0 to 98 (low) 98 to 148 (med) 148+ (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: dd mm yyyy Duties:	☐ Pre-injury Start Date: dd mm yyyy	
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: dd mm yyyy To: dd mm yyyy
		From: dd mm yyyy To: dd mm yyyy
		From: dd mm yyyy To: dd mm yyyy
Additional Requests:		

WCB REMINDER

• E-mail Clinic for Approval

• Update Screen 119