

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.

WCB Claim #:

Health Card #:

**WORKER INFORMATION**

|                                                         |  |             |                                                                                 |          |  |                                                                                                         |  |  |
|---------------------------------------------------------|--|-------------|---------------------------------------------------------------------------------|----------|--|---------------------------------------------------------------------------------------------------------|--|--|
| Worker's Last Name:                                     |  | First Name: |                                                                                 | Initial: |  | Date of Birth:                                                                                          |  |  |
|                                                         |  |             |                                                                                 |          |  | <div>dd</div> <div>mm</div> <div>yyyy</div>                                                             |  |  |
| Date of Injury:                                         |  |             | Is the worker working? Yes <input type="checkbox"/> No <input type="checkbox"/> |          |  | If yes, describe: transitional duties <input type="checkbox"/> pre-injury work <input type="checkbox"/> |  |  |
|                                                         |  |             |                                                                                 |          |  |                                                                                                         |  |  |
| Case Conference scheduled? Yes <input type="checkbox"/> |  |             | Date:                                                                           |          |  | No <input type="checkbox"/> Reason:                                                                     |  |  |
|                                                         |  |             |                                                                                 |          |  |                                                                                                         |  |  |

**SUMMARY**

|                                                                                                                                       |  |                         |  |                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|---------------------------------------------|--|
| Current/Reassessment Date:                                                                                                            |  | # of Treatments:        |  | Current Orebro Score:                       |  |
|                                                                                                                                       |  |                         |  |                                             |  |
| Overall Functional Progress: Improving <input type="checkbox"/> No change <input type="checkbox"/> Declining <input type="checkbox"/> |  | Previous if applicable: |  |                                             |  |
| Comments:                                                                                                                             |  |                         |  | 0 to 98 (low), 98 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 <input type="checkbox"/> No <input type="checkbox"/>                                        |  | Sprain/Strain: Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                  |  |
|                                                                                                                   |  | DDG Date:                                                                                                                                |  |
|                                                                                                                   |  |                                                                                                                                          |  |
| Form E – Physical Abilities Report attached? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, why? |  |                                                                                                                                          |  |
|                                                                                                                   |  |                                                                                                                                          |  |
| Are there flags that influence duration? Yes <input type="checkbox"/> No <input type="checkbox"/>                 |  | Expected RTW: <input type="checkbox"/> Transitional Start Date: <input type="checkbox"/> Pre-injury Start Date: <input type="checkbox"/> |  |
|                                                                                                                   |  |                                                                                                                                          |  |

**JOB MATCH SUMMARY** (refer to Work Capabilities – Definitions)

|                              |                                    |                                |                                 |                                |                                                                  |
|------------------------------|------------------------------------|--------------------------------|---------------------------------|--------------------------------|------------------------------------------------------------------|
| Pre-injury job requirements: | Sedentary <input type="checkbox"/> | Light <input type="checkbox"/> | Medium <input type="checkbox"/> | Heavy <input type="checkbox"/> | Very Heavy <input type="checkbox"/>                              |
| Present work capability:     | Sedentary <input type="checkbox"/> | Light <input type="checkbox"/> | Medium <input type="checkbox"/> | Heavy <input type="checkbox"/> | Very Heavy <input type="checkbox"/> N/A <input type="checkbox"/> |
| Transitional duties:         | Sedentary <input type="checkbox"/> | Light <input type="checkbox"/> | Medium <input type="checkbox"/> | Heavy <input type="checkbox"/> | Very Heavy <input type="checkbox"/>                              |

**COLLABORATIVE TREATMENT PLAN**

|                      |                            |                                                                                                                     |
|----------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------|
| Goals/Methodology:   | Progress related to goals: | Recommended Time Frame                                                                                              |
|                      |                            | <div>From: <div>dd</div><div>mm</div><div>yyyy</div></div> <div>To: <div>dd</div><div>mm</div><div>yyyy</div></div> |
|                      |                            | <div>From: <div>dd</div><div>mm</div><div>yyyy</div></div> <div>To: <div>dd</div><div>mm</div><div>yyyy</div></div> |
|                      |                            | <div>From: <div>dd</div><div>mm</div><div>yyyy</div></div> <div>To: <div>dd</div><div>mm</div><div>yyyy</div></div> |
| Additional Requests: |                            |                                                                                                                     |
|                      |                            |                                                                                                                     |

**WCB REMINDER**

• E-mail Clinic for Approval

• Update Screen 119