

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.



Primary and Emergency
Care Report

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	Injury Location	
Date of injury	mm/dd/yy	mm/dd/yy	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.

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