WCB Nova Scotia
200-137 Venture Run
Dartmouth, NS B3B 0L9

Toll-free: 1-800-870-3331
Fax: 902-491-8001

Physician - Assistive Devices Request Form

Please fax or mail the completed form to us using the information on the form.

WCB Claim Number: _____

Health Card Number: _____

A. REQUEST INFORMATION (to be completed by Case Worker)

To:	Fax Number:	Phone Number:
From:	Fax Number:	Phone Number:
Re:		

B. WORKER INFORMATION (to be completed by Case Worker)

Worker's Last Name:	First Name:	Initial:	Date of Birth (dd/mm/yyyy):
Date of Injury (dd/mm/yyyy):	Body Part Injured:		

C. DEVICE INFORMATION (to be completed by physician; attach additional page if necessary)

Type of Device:	◯ New Device ◯ Replacement Device

If prescribing orthotics or footwear, does the worker have a leg length discrepancy?

◯ Yes ◯ No If yes, please indicate the discrepancy:

Please provide rationale and benefit of device in relation to compensable injury. Where necessary, provide medical and/or scientific evidence to support the request.

D. PHYSICIAN INFORMATION (to be completed by physician; please print)

Physician Name:	Professional Designation:	WCB ID #:
Signature:	Phone Number:	Fax Number: