Physician's Report Completion Guidelines

WORKERS' COMPENSATION BOARD OF NO

Halifax Office
5668 South Street
PO Box 1150

Sydney Office
404 Charlotte St. Suite 200
Sydney, NS B1P 1E2

Physician's Report Form 8/10

General Instructions – Please print clearly in dark blue or black ink. Alternatively, the form can be viewed through Adobe Acrobat, completed electronically (use the tab key to move through each field on the form) and printed. Submit the form by mail or fax to the WCB within 5 business days of the worker's visit. Whenever possible, the worker's claim number should be noted on the form.

** Mandatory Information*

* WORKER INFORMA

Last Name | First Name | Initial | Date of Birth (dd mm yyyy)

Street

Worker Information – Provides the identification information for the worker. This helps properly identify the worker and provides important worker and employer contact information.

Home/Cell Phone | Work Phone | Employer Name | Worker's Job Title/Occupation

* INJURY INFORMATION

Date of Injury: (dd mm yyyy) | Date of Visit: (dd mm yyyy) | Diagnosis: (specify body part)

Subjective Findings:

Objective Findings:

Injury Information – Reflects the physician's diagnosis and the subjective and objective findings of the worker examination. Subjective findings are those reported by the worker. Objective findings are identified by examining the worker, e.g. range of motion, muscle spasm, neurological findings.

* RETURN-TO-WORK PLAN

Is the worker still working? ☐Yes ☐No

Are transitional duties ava

Expected return-to-work date (if applicable): (dd mm yyyy)

Current Work Capabilit
(definitions on back)

Are you aware of any p
If yes, please explain:

Return to Work Plan – Identifies the worker's current abilities in relation to work classification, pre-injury work and any accommodations needed to help the worker's safe and timely return to work. Definitions of the work capabilities (e.g. sedentary, medium, etc.) are found on the back of the form. Ensure you reflect expected return to either pre-injury or transitional work along with a date. Note any pre-existing or current problems/barriers influencing recovery (e.g. diabetes, prior injury to same body part, fear or re-injury, etc.).

* TREATMENT PLAN

	Methodology / Goals	Timeframe
Treatment Plan		
Medications, referrals, tests, Xrays, MRI, etc.		
Follow-up Plan		

Treatment Plan – Outlines the plan and goals for any required medical treatment. Timeframes should be made in consultation with the Medical Disability Advisor (MDA) or surgical protocol, if treatment follows surgery. Include transitional duties where possible. Treatment goals should relate to the pre-injury job requirements. Include any medications (drug name & dosage) and/or referrals needed as a result of the injury. Follow-up plan should outline objectives for the next appointment such as to discuss progress on treatment plan or to review diagnostic tests/ referral results (e.g. if the current plan is to provide medication and support light work, the follow-up may be to re-evaluate in 2 weeks to assess if the plan is on track and if transitional work can proceed based on functional progress).

* PHYSICIAN 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.

Physician's Signature

Physician's Name (pl

Physician Certification – Provides physician identification and contact information. Ensure the physician's name is printed clearly along with phone and fax numbers. It also provides the physician's confirmation on the validity of the report information and associated fees.