wcb Workers Compensation Board - Alberta

C151
PHYSICIAN'S PROGRESS REPORT

PO Box 2415
Edmonton AB T5J 2S5
Fax: (780) 427-5863
1-800-661-1993

WCB Claim Number:

Personal Health Number:

Worker: *Last Name* *First Name* *Middle Name* Date of Birth *(Year / Month / Day)*

Mailing Address: *Apt/Unit* *Street* *City/Town* *Province*

Postal Code: Gender: ☐ Male ☐ Female Telephone Number:

Employer Name: Telephone Number:

Address: *Location of Operations (site #)* *City/Town* *Province*

Physician's Name: Billing Number Telephone Number:

Worker's Job Title/Occupation: Progressive Injury? ☐ Yes ☐ No Date of Injury: *(Year / Month / Day)*

Diagnostic Code 1: Diagnostic Code 2: Diagnostic Code 3: Dominant Hand ☐ Left ☐ Right Date of Exam: *(Year / Month / Day)*

Nature of Injury: Part of Body: Side of Body:

Work-Related Diagnosis:

WCB Services Requested? ☐ Case conference with WCB Manager ☐ Case conference WCB Physician ☐ Referral to Return To Work provider

Will/has the patient miss(ed) work **beyond the date of accident?** (other than for medical appointments). ☐ Yes ☐ No

Has the patient returned to work? ☐ Yes ☐ No If yes, date returned *(Year / Month / Day)*

Worker's current return to work status? ☐ Full duties and hours ☐ Modified Hours _____ hrs/day ☐ Modified duties ☐ Hospitalized

If patient is currently **not working** or is **working modified duties**, complete the following.

	Able	Unable	Limited			Able	Unable	Limited	
Sitting	☐	☐	☐	to ____ Hours	Climbing	☐	☐	☐	
Standing	☐	☐	☐	to ____ Hours	Lifting	☐	☐	☐	Max of _____ (lbs/kg)
Walking	☐	☐	☐	to ____ Hours	Pushing / pulling	☐	☐	☐	
Bending	☐	☐	☐		Overhead reaching	☐	☐	☐	to ____ Hours
Twisting	☐	☐	☐		Driving	☐	☐	☐	
Kneeling/squatting	☐	☐	☐						

Estimated date you expect the patient will be able to perform pre-accident work *(Year / Month / Day)*

Physician's Signature Printed Name Date *(Year / Month / Day)*

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Worker: *Last Name* *First Name* *Middle Name* | WCB Claim Number:

Describe how and when the injury/condition occurred:

Examination
Symptoms:

Objective Findings:

Are you aware of any prior conditions in the same anatomical area? ☐ Yes ☐ No

If yes, describe

Treatment Plan Details

Opioid Medication (Prescription Name/Strength/Daily Intake [tab/ml])

Rx Name	Strength	Daily Intake (tab/ml)

If opioids are being prescribed and date of exam is greater that 60 days from date of accident, please check all that apply:

☐ Patient has undergone surgery in the past 90 days ☐ Patient is being treated for malignant pain ☐ WCB has advised not to submit a Medication Management Report

If none of the above is selected, please complete the following:

Patient side effects for opioid treatment: *(Select all that apply)*

☐ Nausea ☐ Sweating ☐ Depressed mood ☐ Endocrine dysfunction ☐ Fatigue/drowsiness
☐ Constipation ☐ Dry mouth ☐ Sleep disorder/apnea ☐ Cognitive deficits ☐ Worsening pain

Adverse opioid related behaviors: *(Select all that apply)*

☐ Social deterioration ☐ Accessing opioid from other sources ☐ Opioid seeking
☐ Altering route of delivery ☐ Unsanctioned use of opioids ☐ Withdrawal symptoms

Patient's average estimate of pain severity in the last week (0 - 10): _____

Is the current opioid therapy resulting in a reduction in pain levels? ☐ Yes ☐ No If yes, describe the reduction: _____

Provide your own clinical estimate of your patient's level of function at this visit (0 - 10): _____

Treatment Plan and Non-Opioid Medication *(please list any)*:

Consultations/Referrals/Investigations:

Other reasons why the patient cannot work: ☐ Self-reported pain ☐ Opioids/Medication side effects

Other restrictions or additional comments/special considerations:

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