WCB Workers' Compensation Board Alberta

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C050
PHYSICIAN'S FIRST REPORT

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 if)* *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? ☐ Contact with WCB Case Manager ☐ Contact WCB Physician ☐ Referral to Return To Work provider

Will/has the patient miss(ed) work beyond the **date of accident**? (Other than for medial appointments). ☐ Yes ☐ No | Has the patient returned to work? ☐ Yes ☐ No | If yes, date *(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	☐	☐	☐	
Twisting	☐	☐	☐		Driving	☐	☐	☐	to ____ Hours
Kneeling/squatting	☐	☐	☐						

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

Describe how and when the injury/condition occurred.

Symptoms:

Objective Findings:

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

Opioid Medication

Medication Name	Strength	Daily Intake

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:

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.