

Claim Number	7
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Worker Information

Last Name		First Name	
Address			City
Province	Postal Code	Date of Birth (dd/mm/yyyy)	PHIN

Injury Details

Date of Incident	Area of Injury
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Examination Findings and Diagnosis

Date of Examination	ICD Code	Any changes to diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, state new diagnosis		
Subjective Complaints		
Objective Findings (include ROM, muscle testing & neurological status)		
Is recovery satisfactory? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what are the complications/other factors impeding progress?		
Test performed (e.g., X-Ray, CT Scan, MRI, etc.) Attach results	Location	Date
Referred to Consultant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name and address of Consultant	Date of Appointment

Treatment Plan

Description	Date of next visit
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Work Capabilities

When can worker return to regular duties? Date <input type="checkbox"/> Unknown at time of examination	
Is worker capable of alternate or modified work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, outline restrictions:	Duration of restrictions weeks

Physician Information

Physician Name	Address		
Physician Signature	City	Province	Postal Code
	Phone Number	Fax Number	Date