Saskatchewan Workers' Compensation Board
200 - 1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com
Phone: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free fax: 1.888.844.7773

Click on any field to start editing.

CHI

Reset Form

Chiropractor Initial Report

WCB claim number: _____

Worker's name: _____

Clinic name: _____	Provincial Health Number: _____
Clinic number: _____ Provider number: _____	Date of birth: _____ (MM/DD/YYYY) Phone: _____
Phone: _____ Fax: _____	Employer name: _____
Care provider's name, address, postal code	Worker's name, address, postal Code
Print/Stamp/Sticker	Print/Stamp/Sticker

Recurrent treatment? ☐ No ☐ Yes. If yes, approx. last treatment date _____ (MM/DD/YYYY) (WCB approval required)

CLINICAL

1. Date of injury: _____ (MM/DD/YYYY) 2. Date of this exam: _____ (MM/DD/YYYY)
3. Part of body injured: _____
4. Diagnosis: _____
5. Mechanism of injury: _____
6. Subjective complaints: _____
7. Objective clinical findings: (including quantifiable measures such as ROM in degrees/percentage, manual muscle testing graded out of 5, SLR, DTR, sensation, limb girth) etc. _____
8. Functional outcome measure: Roland Morris _____ Quick Dash _____ QD work module _____ NDI _____ LEFS _____
9. Assessment of recovery (0-10) status _____ (0 = no recovery, 10 = recovered to preinjury) 10. Intensity score ☐ 0 ☐ 1
11. Are you aware of previous injury/treatment for this area? ☐ No ☐ Yes Date: _____ (MM/DD/YYYY)

Explain _____

MANAGEMENT

12. Investigations ordered: if applicable ☐ x-ray ☐ CT ☐ MRI ☐ Other: _____
13. Management plan: ☐ Medication ☐ Chiropractor ☐ Physical therapist ☐ Massage ☐ Specialist ☐ Surgery
☐ Secondary/Tertiary treatment ☐ Other
Provide details _____
14. Treatment plan: ☐ Biomechanical ☐ Electro-physical agent
☐ Regional conditioning ☐ Supervised _____ ☐ Home
☐ Supervised global conditioning _____
☐ Education ☐ Transitional RTW ☐ Other _____
15. Frequency of treatment: _____ per week, Other _____
Expected date of discharge from treatment _____ (MM/DD/YYYY)

When writing to the WCB, please print name and claim or firm number.

MISSION: ZERO

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Chiropractor Initial Report

WCB claim number: _____

Worker's name: _____

16. Have you contacted the employer regarding current restrictions?

☐ Yes Date of contact _____ (MM/DD/YYYY) Name: _____

☐ No

RETURN TO WORK

17. Is the worker off work as a result of the work injury? ☐ Yes ☐ No

Who advised the worker to be off work? ☐ Chiropractor ☐ Physical therapist ☐ Medical doctor ☐ Worker has taken themselves off work

If off of work how long do you anticipate the worker to be off work? _____ ☐ days ☐ Other _____

Has a return to work been arranged? ☐ Yes ☐ No If yes, who arranged the RTW? ☐ Chiropractor ☐ Physical therapist ☐ Medical doctor ☐ Employer. Name: _____

If no, please explain: _____

18. Return to work date: _____ (MM/DD/YYYY)

19. If worker is at work: Are they currently working with restrictions? ☐ No ☐ Yes

How long are restrictions expected to remain? _____ ☐ days ☐ Unknown Other _____

20. Estimated current restrictions? ☐ Subjective ☐ Objective

☐ Lifting _____ lbs ☐ Pushing/pulling _____ lbs ☐ Reaching _____

☐ Overhead reaching _____ ☐ Turning ☐ Walking _____ ☐ Stairs _____

☐ Ladders _____ ☐ Standing (hours) _____ ☐ Sitting (hours) _____

☐ Environment _____ ☐ Other _____

Client and practitioner agreed: ☐ Yes ☐ No (explain in comments)

21. Would you like to complete the Electronic Return to Work Form(PRTW)?

☐ Yes ☐ No (RTW form needs to be completed 1 week before RTW).

22. Comments RTW _____

23. General comments: _____

Signature: Please sign form before mailing/faxing. Date: _____ (MM/DD/YYYY)

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MISSION: ZERO