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.

CHP

Chiropractor Progress 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 name, address, postal code	Worker name, address, postal code
Print/Stamp/Sticker	Print/Stamp/Sticker

Request for extension ☐ Denied CES/CCF ____________ Date: ______ (MM/DD/YYYY)

CLINICAL

1. Date of this exam: ______ (MM/DD/YYYY)
2. Current diagnosis: ____________
3. Body areas currently being treated: ____________
4. Subjective complaints: ____________
5. 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. ____________
6. Self report(Initial/Current): Roland Morris ___/___ Quick Dash ___/___ QD work module ___/___ NDI ___/___ LEFS ___/___
7. Assessment of recovery status(0-10) ______ (0 = no recovery, 10 = recovered to preinjury)
8. Discharge from treatment ☐ No ☐ Yes. If Yes, date of discharge: ______ (MM/DD/YYYY)

   Did the worker return to their regular duties? ☐ Yes ☐ No

MANAGEMENT

9. Results of diagnostics since previous report if applicable: ____________
10. Management plan: ☐ Medication ☐ Chiropractor ☐ Physical therapist ☐ Massage ☐ Specialist ☐ Surgery ☐ Secondary/Tertiary treatment ☐ Other

    Provide details ____________
11. Treatment plan: ☐ Biomechanical ☐ Electro-physical agent ☐ Regional conditioning Supervised ______ Home ______ ☐ Supervised global conditioning ☐ Education ☐ Transitional RTW ☐ Other ____________
12. Frequency of treatment: ______ per week, Other ____________

    Expected date of discharge from treatment ______ (MM/DD/YYYY).
13. Are you aware of other health or non-health factors affecting recovery: ☐ Yes ☐ No Explain: ____________
14. Would you like WCB to arrange/expedite: ☐ Diagnostic ☐ Specialist ☐ Assessment team review ☐ Other

    Details: ____________

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

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Chiropractor Progress Report

WCB claim number: ____________________

Worker's name: ____________________

15. Have you contacted the employer regarding current restrictions? ☐ Yes Date of contact ____________ MM/DD/YYYY

☐ No Please explain: ____________________

RETURN TO WORK

16. 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: ____________________

17. Return to work date: ____________ MM/DD/YYYY

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

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

Anticipated date of full hours/duties: ____________ MM/DD/YYYY

19. Estimated current restrictions? ☐ Subjective ☐ Objective

☐ Lifting ________ ☐ Pushing/pulling ________ ☐ Reaching ________

☐ Overhead reaching ________ ☐ Turning ☐ Walking ________ ☐ Stairs ________

☐ Ladders ________ ☐ Standing (hours) ________ ☐ Sitting (hours) ________

☐ Environment ____________________ ☐ No restrictions

☐ Other ____________________

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

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

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

21. Comments RTW ____________________

22. General comments: ____________________

Signature: Please sign form before mailing/faxing. Date: ____________ MM/DD/YYYY

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