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.

PPP

Reset Form

Physician's Progress/Discharge Report

WCB claim number: _____

Worker's name: _____

Clinic name: _____

Clinic number: _____ Doctor number: _____

Phone: _____ Fax: _____

Physician's name, address, postal code

Provincial Health Number: _____

Date of birth: _____ Phone: _____

MM/DD/YYYY

Employer name: _____

Worker's name, address, postal code

INJURY

Examination date: _____

MM/DD/YYYY

1. Part of body injured: _____ 2. Diagnosis: _____

3. Subjective complaints: _____

4. Objective findings: _____

5. Results of diagnostics since previous report (forward): _____

6. Assessment of recovery (0-10) current: _____ 0 = none, 10 = pre-injury

Explain any delay in recovery: _____

7. Have you advised the patient to be off work due to the injury? ☐ Yes ☐ No (if yes, complete 8 to 18)

If no, is the patient to be working with restrictions? ☐ Yes ☐ No (if yes, complete 8 to 18)

ADDITIONAL INFORMATION

8. Investigations ordered: ☐ X-ray ☐ CT ☐ MRI ☐ Blood work ☐ None ☐ Other: _____

9. Treatment plan: ☐ Medication* ☐ Physical therapist* ☐ Chiropractor* ☐ Massage* ☐ Specialist* ☐ Hospitalized*
☐ Education ☐ Exercise ☐ Transitional RTW ☐ No treatment required

*Please name (med., caregiver): _____

10. Would you like the WCB to arrange/expedite? ☐ Diagnostic ☐ Specialist ☐ Assessment type/name: _____

11. Are you aware of other health or non-health factors affecting recovery? ☐ No ☐ Yes (if yes, add to comments)

12. Estimated restrictions include: ☐ Lifting _____ lbs ☐ Pushing/pulling _____ lbs ☐ Reaching: _____
☐ Overhead reaching: _____ ☐ Turning ☐ Walking: _____ ☐ Stairs: _____
☐ Ladders: _____ ☐ Standing (hrs) _____ ☐ Sitting (hrs) _____ ☐ Environment: _____
☐ None ☐ Other: _____

13. Effects of the injury may affect activity for: _____ days if <8 days ☐ 8-14 days ☐ 15-21 days ☐ > 21 days
RTW date: _____

MM/DD/YYYY

14. Has transitional RTW been discussed with the worker? ☐ Yes ☐ No The employer? ☐ Yes ☐ No

15. Has a transitional RTW been arranged? ☐ Yes TRTW start date: _____ ☐ No (explain in comments)

MM/DD/YYYY

16. Are there any specific safety or medication concerns in a TRTW? ☐ No ☐ Yes (explain in comments)

17. Comments: _____

18. Next appointment date: _____

MM/DD/YYYY

Signature Please sign form before mailing/faxing. Date: _____ Copy to: _____

MM/DD/YYYY

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