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First Medical Report

Complete this form and return it, with your invoice, to the address on the reverse.

Worker Information

Last Name	First Name	
Mailing Address (include postal code)	Community	Telephone (include area code)
Employer	Worker's Occupation	
Date of Injury MM DD YY	Date of Birth MM DD YY	Gender ☐ M ☐ F

Health Care Provider Information

Name of Health Care Provider (please print)	Address (include postal code)
Telephone (include area code)	
Date of Exam MM DD YY Time	

Subjective

Worker's description of injury.
Describe complaints.

Objective

Describe **objective** findings, including any diagnostic results.	
Diagnosis:	
Treatment plan and medication:	
Any follow-up plan? ☐ Yes ☐ No	Date of follow-up visit MM DD YY
Any factors that may complicate recovery? *(e.g., a pre-existing condition)* ☐ Yes ☐ No *If yes, please explain, attaching details if needed.*	
Is worker fit to return to work with no restrictions? ☐ Yes ☐ No **If no, complete Functional Abilities on the reverse side.**	

The WSCC may use this information for the administration of the *Workers' Compensation Acts*, the *Safety Acts*, and/or the *Mine Health and Safety Acts*, and their associated *Regulations*.

I hereby certify the above is a correct statement of services personally rendered by myself.

Health Care Provider's Signature **Please print form to sign.** Date MM / DD / YY

CS003 0713

Functional Abilities

Worker's Last Name	First Name	Claim Number

Identify the worker's overall abilities and restrictions.

A. Abilities and Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3.

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

2. Please indicate **Restrictions** that apply. Include additional details in section 3.

- ☐ Bending/twisting repetitive movement of: (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environment exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s):

Left		Right
☐	Gripping	☐
☐	Pinching	☐
☐	Other (please specify)	☐

- ☐ Limited pushing/pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify). Do not include names of medications.
- ☐ Exposure to vibration:
  - ☐ Whole body
  - ☐ Hand/arm

3. Additional comments on **Abilities and Restrictions.**

_____

_____

4. From the date of this assessment, the above will apply for approximately:
☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with the worker?
☐ Yes ☐ No

6. Recommendation for work hours and start date:
Start Date: MM | DD | YY

☐ Regular full-time hours
☐ Modified hours
Please specify:
☐ Graduated hours
Please specify:

B. Date of Next Appointment

Recommended date of next appointment to review **Abilities and Restrictions.** MM | DD | YY

I have provided this completed Functional Abilities form to the worker:
☐ Yes ☐ No Date: MM | DD | YY

Health Care Provider's Signature: **Please print form to sign.**

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wscc.nt.ca or **wscc.nu.ca**

Ce formulaire est disponible en français
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