Safety Matters @Work
Workers Compensation Board of PEI

PHYSICIAN FORM 8

P.O. Box 757, 14 Weymouth St, Charlottetown, PE C1A 7L7 www.wcb.pe.ca
Phone: (902) 368-5680 Toll-free: 1-800-237-5049 Fax: (902) 368-5696

Claim #:	PHN:	DOB: D D M M Y Y	Provider #:
Last Name:		Clinic Name:	Physician Name:
First Name:		Clinic Address:	
Address:			Fee Code(s):

Date of Accident D D M M Y Y | Visit Date D D M M Y Y | Time from Injury: ❑ 0-4 wks ❑ 4-6 wks ❑ 6-8 wks ❑ 8-12 wks ❑ >12 wks

❑ New Injury (Please provide description of accident/injury & clinical findings) ❑ Follow-up (Please provide clinical findings)

❑ **Soft tissue injury**
❑ Acute strain/sprain (or) ❑ Repetitive strain injury

Body part
❑ Head ❑ Upper back
❑ Neck ❑ Low back
❑ Shoulder ❑ Hip/thigh
❑ Forearm ❑ Knee
❑ Wrist ❑ Ankle/foot

Side
❑ Left ❑ Right

Clinical evidence of internal derangement?
❑ No ❑ Yes ❑ MRI ordered?

Clinical evidence of nerve impingement?
❑ No ❑ Yes ❑ MRI ordered?

Head injury severity (GCS _____/15)
❑ Mild head injury ❑ mTBI ❑ TBI

❑ **Other:** eg. Burn, Psychological, Occupational

Description of accident/injury (first visit only) **/ Clinical findings:**

❑ **Fracture**
❑ Closed ❑ Compound
Bone(s)_____
❑ Referred ortho/plastics Dr. _____ (cc WCB)

Best working diagnosis

Pain rating scale ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 **Progress** ❑ Improved ❑ Unchanged ❑ Regressed

Diagnostics ordered ❑ X-ray ❑ MRI ❑ EMG ❑ Other _____

Treatment ❑ NSAID/analgesics ❑ Physio/Chiro ❑ Injection ❑ Specialist referral: Dr. _____ (cc WCB)
Rx (New, D/C, Change) _____

Return to work plan
❑ Confined to home/bedridden
❑ OT/Physio to plan RTW/Ease back with employer and/or complete functional assessment
❑ I have completed employer's RTW Planning Form (please copy to WCB)
❑ Able to remain at work at full duties

Are there barriers to return to work?
❑ Injury related (eg. injury severity, pre-existing condition)
❑ Pain related (eg. fear avoidance, catastrophizing)
❑ Work related (eg. not job attached, fear that work is harmful)
❑ Other (eg. mental health, substance dependence/abuse, psychosocial)

Signature(s) Date: D D M M Y Y Next Visit: D D M M Y Y

Information on this form is required for the purposes of administering claims for workers compensation under the authority of sections 18(9) and 59(2) of the Workers Compensation Act. The Workers Compensation Board is authorized to collect this information under section 31 of the Freedom of Information and Protection of Privacy Act. If you have any questions about this collection of information, please contact: FOIPP Coordinator, Workers Compensation Board of PEI, 14 Weymouth Street, P.O. Box 757, Charlottetown, PE C1A 7L7, (902) 368-5680 or toll free at 1-800-237-5049.