



Visiting Specialists' Clinic & Diagnostic Imaging Records

PATIENT: Please take this form to your family physician for completion.

PHYSICIAN: Please fax form to WorkSafeBC at the number provided below. Please invoice fee code 19909

CLAIMS CALL CENTRE

Phone 604 231-8888
Toll-free 1 888 967-5377

FAX

604 233-9777
Toll-free **1 888 922-8807**

MAIL

WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

Worker last name	First name	Middle initial	WorkSafeBC claim number
Date of birth (yyyy-mm-dd)		Personal health care number (CareCard number)	

Patient's name	Date of service (date of assessment)
Proposed surgery	
History of present illness	
Past history surgery	
Allergies	
Lab work if indicated <ul style="list-style-type: none"> • CBC • Na, K, C1 • Creatinine • ECG (if over 50 or if indicated) • PT • INR • Urinalysis 	





Worker last name	First name	Middle initial	WorkSafeBC claim number
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Review of systems		Smoker	Yes <input type="checkbox"/> No <input type="checkbox"/>
<u>Cardiac</u>	None <input type="checkbox"/>	<u>Endocrine</u>	None <input type="checkbox"/>
Hypertension <input type="checkbox"/>		Diabetes <input type="checkbox"/>	
MI <input type="checkbox"/>		Diet controlled <input type="checkbox"/>	
Angina <input type="checkbox"/>		Oral hypoglycemics <input type="checkbox"/>	
CHF <input type="checkbox"/>		Insulin controlled <input type="checkbox"/>	
Cardiac arrhythmias <input type="checkbox"/>		Thyroid disease <input type="checkbox"/>	
<u>Respiratory</u>	None <input type="checkbox"/>	<u>GI/GU</u>	None <input type="checkbox"/>
Asthma <input type="checkbox"/>		Peptic ulcer <input type="checkbox"/>	
COPD <input type="checkbox"/>		Renal failure <input type="checkbox"/>	
		Malabsorption disorder <input type="checkbox"/>	
		GE reflux <input type="checkbox"/>	

Physical examination				
Height	Weight	Body Mass Index	Blood pressure	Heart rate
Head and neck				N.A.D. <input type="checkbox"/>
Heart				N.A.D. <input type="checkbox"/>
Lung				N.A.D. <input type="checkbox"/>
Abdomen/Pelvic if indicated				N.A.D. <input type="checkbox"/>
Musculoskeletal/Neurological				N.A.D. <input type="checkbox"/>

Signature		Name (please print)		
Address		City	Postal Code	
Phone number (please include area code)	Fax number (please include area code)	MSP billing number		

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.

