RESET

WorkSafeBC

Extension of Massage Therapy Treatment Request

Submit this form to request an extension for massage therapy treatment beyond 8 weeks (> 60 days) from the date of injury. Approval is required before providing services. All fields must be completed.

Date of report (yyyy-mm-dd)	Number of pages submitted
	2

Number of request(s)

Is this the first request for an extension?	If no, indicate the date of the last approved extension request (yyyy-mm-dd)
☐ Yes ☐ No	

Worker's information

Last name	First name	Middle initial	WorkSafeBC claim number
Phone number (include area code)	Date of birth (yyyy-mm-dd)	Personal health number (BC Services Card/CareCard)	
Date of injury (yyyy-mm-dd)	Injury accepted on the claim	Side of the body ☐ Left ☐ Right ☐ Both	

Employment and job information

Did the worker report any time loss from work due to the injury?
☐ Yes ☐ No

Is the worker currently working?
☐ Yes ☐ No

If yes, please select one
☐ Full duties ☐ Modified duties

If no, please explain

Treatment information

Initial assessment date (yyyy-mm-dd)	Treatment dates after initial assessment (yyyy-mm-dd)	Total number of visits

Description of treatment provided to date (provide details)

Has the worker's condition improved?
☐ Yes ☐ No

Please explain

Are there any factors delaying recovery and/or are there additional barriers?

Rationale for request

Explain why this worker requires an extension of treatment.

Extension of Massage Therapy Treatment Request

Worker's last name	First name	Middle initial	WorkSafeBC claim number

Significant subjective findings (i.e., self-report, mechanism of injury, chief complaint, current/past history, symptoms [pain scale], aggravators/alleviators, functional limitations [Activities of daily living (ADLs)], work-related)
Significant objective findings (i.e., observations, palpation, posture, range of motion, orthopedic testing [functional tests, special tests] unless contraindicated)
Additional information that may assist in decision for further treatment. (i.e., expected benefit, return to work).

Proposed treatment plan

Proposed type(s) of treatment (i.e., manual technique, remedial exercise)		
Proposed number of treatments and frequency (i.e., average number of visits per week)	Start date of proposed treatment (yyyy-mm-dd)	End date of proposed treatment (yyyy-mm-dd)
Is the worker expected to return to work following additional treatment? ☐ Yes ☐ No ☐ Currently at work		

Provider's information

Clinic name		Fax number (include area code)	Payee number
Address	City	Province	Postal code
Phone number (include area code)	Registered Massage Therapist's name		
Do you have a physician's referral? ☐ Yes ☐ No			

Claims Call Centre
Phone 604.231.8888
Toll-free 1.888.967.5377
M–F, 8 a.m. to 6 p.m.

Fax
604.233.9777
Toll-free 1.888.922.8807

Mail
WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's FIPP Office, at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or email **FIPP@worksafebc.com**, or call 604.279.8171.