Naturopathic First Report

RESET

Naturopathic Physician — This Report Needs To Be Completed And Submitted Only When:

1. The worker will be disabled beyond the day of injury, or
2. If the claim is for Hernia, Back Condition, Shoulder or Knee Strain or Sprain, Occupational Disease, or
3. If WorkSafeBC (the Workers' Compensation Board) has requested this report.

The *Workers Compensation Act* requires that every physician's or qualified practitioner's first report, containing all the information requested, shall be furnished to WorkSafeBC within 3 days after the date of first attendance to the worker.

Completed reports are to be submitted via **FAX** to WorkSafeBC at the number provided below

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

Worker's information

				WorkSafeBC claim number
Mr. ☐ Mrs. ☐ Dr. ☐ Ms. ☐ Miss ☐	Worker's last name		First name	Middle initial
Address line 1			Address line 2	
City	Province/State	Country (if not Canada)	Postal Code/Zip	Phone number (please include area code)
Gender Male ☐ Female ☐	Date of injury (yyyy-mm-dd)		Location of plant or project where injury occurred	
Who rendered first treatment? (if known)				Date first treated (yyyy-mm-dd)
Date of birth (yyyy-mm-dd)		Personal health number (BC Services Card/CareCard)		
Are you the worker's regular practitioner? Yes ☐ No ☐	If yes, how long has the worker been your patient? Less than 6 months ☐ More than 6 months ☐		Check this box if the injury resulted from a specific incident ☐	
Are there prior or other problems affecting injury, recovery, and disability? Yes ☐ No ☐ If yes please explain				

Employer's information

Employer name (as registered with WorkSafeBC)			Employer phone number (include area code)
Address line 1	Address line 2		
City	Province/State	Country (if not Canada)	Postal Code/Zip
Worker's occupation	Employer's type of business		

Report prepared by

1. Date of service (yyyy-mm-dd)			
2. What happened (how the injury occurred)	3. Examination describe fully (Please specify right or left)		
4. Diagnosis (text)			
5. Side of body Left ☐ Right ☐ Both ☐ Not applicable ☐			
6. Have X-rays been taken of this? Yes ☐ No ☐ If YES, please send report to WorkSafeBC immediately	7. Have X-rays been taken previously? Yes ☐ No ☐ If YES, for what part of the body and when? (yyyy-mm-dd)		
8. Treatment (including any operative procedure and date)		9. Frequency of treatment	

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		WorkSafeBC claim number
Worker's last name	First name	Middle initial
Date of birth (yyyy-mm-dd)	Personal health number (BC Services Card/CareCard)	

10. Date of next visit (yyyy-mm-dd)	11. Did the worker miss any time from work beyond the date of injury or exposure? Yes ☐ No ☐	12. Last day worked (yyyy-mm-dd)

13. Should the worker be referred for therapy, specialist consultation or diagnostic imaging? If yes, indicate type. If referral (yyyy-mm-dd)

Rehabilitation program ☐ Therapy ☐

Specialist consultation ☐ Diagnostic imaging ☐

PLEASE NOTE

- If, during treatment or convalescence, a worker wishes to leave BC, either temporarily or permanently, the worker must receive permission from both WorkSafeBC and the attending Naturopathic Physician. **Failure to do so may result in suspension of compensation benefits.**
- If you become aware of a worker's intention to leave the province, please advise the worker of the above requirements and notify the appropriate WorkSafeBC office.

Return to work planning

1. Has the worker returned to work Yes ☐ No ☐	2. If YES, date (yyyy-mm-dd)

3. If NO:

a) What are the current physical and/or psychological restrictions?

b) Estimated days before the worker will be able to return to **transitional** or **modified** duties
Currently at work ☐ 1–6 days ☐ 7–13 days ☐ 14–20 days ☐ 21–27 days ☐ > 28 days ☐

c) Estimated days before the worker will be able to return to full shifts
Currently at work ☐ 1–6 days ☐ 7–13 days ☐ 14–20 days ☐ 21–27 days ☐ > 28 days ☐

d) Estimated date of full maximal medical recovery full recovery or best possible recovery (yyyy/mm/dd)

4. Are there any modified or transitional duties available? Yes ☐ No ☐	5. Have the modified or transitional duties been offered to the worker? Yes ☐ No ☐
6. If yes, please describe the modified or transitional duties.	7. Would you like a WorkSafeBC physician or nurse advisor to contact you regarding this patient? Yes ☐ No ☐ Comment

Payee name	Payee number	Practitioner name	Practitioner number
Stamp or type name and address of naturopathic physician or group and personally sign	Address line 1	City	Postal code/zip
	Address line 2		Province/State
	Phone number (please include area code)		Country (if not Canada)
	Signature of naturopathic physician		Date (yyyy-mm-dd)

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 freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.