WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

RESET

NATUROPATHIC PHYSICIAN'S FIRST REPORT

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, 8:00 a.m. to 4:30 p.m.

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

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

Worker information

WorkSafeBC claim number

Mr. ❒ Mrs. ❒ Dr. ❒ Ms. ❒ Miss ❒ | Worker 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 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 information

Employer name *(as registered with WorkSafeBC)* | Employer phone number *(please 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

Details of injury and clinical findings

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 body and when? *(yyyy-mm-dd)*

8. Treatment *(including any operative procedure and date)*

9. Frequency of treatment

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Naturopathic Physician's First Report *(continued)*

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

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 referred, date of 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 ❒ Comments

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)*	

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.