WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

RESET

# NATUROPATHIC PHYSICIAN'S PROGRESS/FINAL REPORT

**SELECT ONE ONLY:** **Progress Report** ❒ **Discharge Report** ❒

The *Workers Compensation Act* requires that a report be submitted to WorkSafeBC within 3 days after the worker is, in the opinion of the physician or qualified practitioner, able to resume work and, if treatment is being continued after resumption of work, to furnish further adequate reports.

**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 ❒<br>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 | |

## Clinical/discharge information

| | |
|---|---|
| 1. Date of service *(yyyy/mm/dd)* | 2. Date you discharged worker from your care if applicable *(yyyy-mm-dd)* |
| 3. What is your final diagnosis in this case? | |
| 4. Remarks on current condition and/or discharge status | |
| 5. Did the worker miss any time from work beyond the date of injury or exposure? Yes ❒ No ❒ | 6. Last day worked *(yyyy-mm-dd)* |

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# Naturopathic Physician's Progress/Final Report *(continued)*

| Worker last name | First name | Middle initial | WorkSafeBC claim number |
|---|---|---|---|
| | | | |

| Social insurance number | Personal health number from BC CareCard |
|---|---|
| | |

## Return-to-work planning

1. Has the worker returned to work? Yes ❒ No ❒ — 2. If YES: Date *(yyyy-mm-dd)*

3. Are there any modified or transitional duties available? Yes ❒ No ❒

4. 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)*

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 ❒

| 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)* | |

## Additional information

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.