



401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, Telephone: (867) 667-5645, Toll free: 1-800-661-0443, Fax: (867) 667-8740, Website: www.wcb.yk.ca

WORKER'S INFORMATION		DOCTOR'S INFORMATION		
Worker's Surname		Doctor's Name		
First Name		Doctor's Address		
<input type="checkbox"/> Male	Telephone #	Doctor's Telephone #		
<input type="checkbox"/> Female				
Date of Birth (d/m/y)		Billing Code		
Worker's Address				
Health Care No. <input type="checkbox"/> Yukon <i>If other, specify jurisdiction</i>		<i>or Health Care Provider's Stamp</i>		
<input type="checkbox"/> Other				
Date of Injury (d/m/y)		Worker's Family Doctor		
Employer		Total \$		
Worker's Occupation		Date of Visit (d/m/y)		Time of Visit

SUBJECTIVE

Worker's description of mechanism of injury

Describe complaints

OBJECTIVE

Describe objective findings, including any diagnostic results

Diagnosis

Treatment plan and medication

Any follow-up plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of follow-up visit (y/m/d):	Please attach a Functional Abilities form (and give a copy to the worker).
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Any factors that might complicate recovery? (e.g., a pre-existing condition) Yes No *If yes, please explain, attaching details if needed.*