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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>		Amount \$		
<input type="checkbox"/> Other				
Date of Injury (d/m/y)		or Health Care Provider's Stamp		
Employer				
Worker's Occupation		Worker's Family Doctor		
		Total \$		
		Date of Visit (d/m/y)		
		Claim Number		

SUBJECTIVE/OBJECTIVE
Any change in diagnosis? <input type="checkbox"/> Yes, (please explain) <input type="checkbox"/> No
Describe subjective complaints, objective findings, and lab or x-ray results
Treatment plan and medication

INVESTIGATION		
Refer to specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, should YWCHSB arrange this? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of specialist
Date of follow-up visit (d/m/y)	Please attach a Functional Abilities form if abilities have changed significantly (and give a copy to the worker).	Refer to YWCHSB's Medical Consultant for assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Factors complicating recovery <input type="checkbox"/> Yes, (please explain) <input type="checkbox"/> No		Would you like to receive copies of decisions on this claim <input type="checkbox"/> Yes <input type="checkbox"/> No