Yukon Workers' Compensation Health and Safety Board

CHIROPRACTOR'S FIRST REPORT AND ASSESSMENT

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

Please contact YWCHSB before providing care if you have not signed a service agreement: Work is Healthy

WORKER'S INFORMATION

Last Name	
First Name	
Address	City
Territory/Prov.	Postal Code
Telephone #	Date of Birth (d/m/y)
Has worker filed a claim? ☐ Yes ☐ No	Claim # or Part of body
Date of Injury (d/m/y)	
Employer	

DOCTOR'S INFORMATION

Name	
Address	
Telephone #	Fax#
Date of Visit (d/m/y)	
Family doctor	

ASSESSMENT

Worker's description of injury and symptoms

Objective data (range of motion, functional testing, observations, etc.)

Chiropractor's Diagnosis

Has the worker had a similar injury in the past? ☐ Yes ☐ No

If **Yes**, explain

When did this occur? (m/y) _____

Continue to page 2

RETURN TO WORK

Worker's current occupation _____

Does the worker report modified duties available at workplace to remain at work? ☐ Yes ☐ No

Have you educated the worker about recovery while at work? ☐ Yes ☐ No

If **no**, explain

BARRIERS TO RETURN TO WORK

Are there barriers to return to work? ☐ Yes ☐ No
If there are barriers to return to work, complete and attach Appendix 1.

TREATMENT PLAN

Recommended treatment

Recommended duration and frequency of treatment

Recommended/prescribed equipment or supplies

Doctor's Signature _____ Date (d/m/y) _____

YWCHSB Chiropractic Treatment Authorization

Provider _____ Provider's Fax # _____

Proposed treatment end date (d/m/y) _____

Claim owner _____ Claim owner phone # _____

☐ Treatment plan approved ☐ Treatment not approved ☐ Claim denied ☐ Call to discuss

YWCHSB Signature _____ Date (d/m/y) _____

This information is being collected for the purposes of administering and enforcing the *Workers' Compensation Act* and is collected under the authority of that Act and the *Access to Information and Protection of Privacy Act*. If you have any questions about the collection of this information, please contact the Privacy Officer at YWCHSB at the above listed address or at (867)667-5645 or 1-800-661-0443.

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APPENDIX 1: BARRIERS TO RETURN TO WORK

Please attach this completed Appendix to the Initial Assessment Report, Progress Report, or Discharge Report if applicable.

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WORKER INFORMATION

Full Name	Worker has filed a claim with YWCHSB ☐ Yes ☐ No
Date of injury (d/m/y)	Claim #
Part of body (if no Claim #)	

BARRIERS FOR RETURN TO WORK

Injury related: Issues related to the nature & severity of the injury.	Pain related: Maladaptive attitudes, beliefs & behaviours in relation to pain	Work related: Issues related to the ergonomic or psychosocial aspects of work	YWCHSB related: Issues related to YWCHSB & case management
☐ Severity	☐ Fear avoidance	☐ Not job attached	☐ Conflict towards WCB
☐ Concurrent condition	☐ High pain sensitivity	☐ Lack of suitable modified work	☐ Poor attendance
☐ Multiple prior injuries	☐ Catastrophizing	☐ Poor work relationships	☐ Poor compliance
☐ Advice of extended rest off work	☐ High intake of medications	☐ Heavy job demands	☐ Other
☐ Deconditioned	☐ Other	☐ Fear that work is harmful	
☐ Other		☐ Other	

Please describe other

Signature _____ Date (d/m/y) _____

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