WCB Workers' Compensation Board Alberta

Box 2415
Edmonton AB T5J 2S5
Fax 780-427-5863
1-800-661-1993

C582
OCCUPATIONAL INJURY SERVICE
PROGRESSIVE INJURY - PHYSICIAN'S REPORT

Please print clearly / or type

Completion guide on reverse of page 2

Patient's *(Surname)*	*(First Name)*	*(Initial)*	WCB Claim Number
			Personal Health Number
			Date of Birth *(Year / Month / Day)*
Address *Street*	*City/Town*	*Province*	*(Postal Code)*
Telephone Number	Date of Accident *(Year / Month / Day)*		Is the patient working? ☐ Yes ☐ No
Date of First Visit *(Year / Month / Day)*	Date of Early Intervention Rep *(Year / Month / Day)*		Weight / Height
			Number of additional pages enclosed # ☐

1. Diagnosis:

2. History:

2.1 Subjective complaints:

2.2 Occupation:

Present Occupation:	Length of time in current position:	Length of time in current occupation:	Length of time with current employer:

2.3 Risk factors (if yes, provide description below)

2.3.1 Occupational:

	Yes	No
1. sustained and awkward position	☐	☐
2. excessive manual force	☐	☐
3. high rates of repetitive movement	☐	☐
4. unusual or forceful movement	☐	☐
5. load factors	☐	☐
6. working environment	☐	☐
7. exposure to vibration	☐	☐
8. other	☐	☐

2.3.2 Non-Occupational:

	Yes	No
1. activities of daily living	☐	☐
2. medical conditions - Describe	☐	☐
3. previous trauma/surgery - List	☐	☐
4. history of similar complaints	☐	☐
5. medication - List	☐	☐
6. personal history smoking/alcohol, other substance abuse	☐	☐
7. posture, if relevant given diagnosis	☐	☐
8. significant anatomical and biomechanical variance	☐	☐
9. history of hobbies/sports-past and present - List	☐	☐
10. 2nd job/volunteer duties	☐	☐

Description of occupational risk factors:

Description of non occupational risk factors:

Patient's *(Surname)* *(First Name)* *(Initial)*	WCB Claim Number

3. Physical Examination:

List all abnormal/significant positive and negative findings on which you base your diagnosis.

4. Tests ordered:

If available, note results and send copies of reports

Test	Result	Copy of report sent: Yes	Copy of report sent: No
		☐	☐
		☐	☐
		☐	☐
		☐	☐

5. Referrals made:

Provide type, practitioner/clinic name and appointment date

6. Treatment:

7. Work restrictions and duration:

8. Expected return to work date:

(Complete if no Early Intervention Report C-578 is submitted) *(Year / Month / Day)*

8.1 Modified work (as in 7 above if any)

8.2 Pre-accident employment *(Year / Month / Day)*

Name and Address to whom fee is payable: (please print)	Signature:	
	Print Name:	
WCB billing number.	Date *(Year / Month / Day)*	Telephone Number

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Occupational Injury Service
Progressive Injury - Physician's Report
Completion Guide

Note: Use additional paper if required. If additional pages are provided, note form number , page number, date and claim number on the bottom left corner. (i.e. C-582, page 2 of 3, YY/MM/DD, 123-4567)

Occupational risk factors:

Describe exactly what the patient is doing regarding the risk activity, e.g.

- frequency of risk activity per hour, per day
- force required for risk activity
- time frame risk activity has been performed
- recent changes in volume, pattern, time frame of risk activity
- length of shift - include scheduled breaks, # of shifts for a given time period
- for lifting activities, describe weight and type (e.g. floor to waist, ...) and frequency

Non occupational risk factors:

include reference to:

- ADL - housekeeping duties and home activities, e.g. child rearing, care for elderly
- medical conditions - including pregnancy, diabetes, hypothyroidism, rheumatoid arthritis
- previous trauma - provide complete medical/surgical history
- similar or related complaints - site specific and body quadrant
- medications - <u>all</u> medications, including contraceptives

Subjective complaints:

include what specific activities (occupational and non-occupational) cause most complaints/symptoms and activities which can no longer be performed.

Physical Examination:

include bilateral findings

Treatment:

also include physical therapy, chiropractic therapy

Work Capabilities:

Reference: The Canadian Classification and Dictionary of Occupations

Sedentary

- Lifting 10 lbs. maximum
- Occasional lifting and/or carrying
- Primarily sitting, with occasional walking/standing

Light

- Lifting 20 lbs. maximum
- Frequent lifting and /or carrying up to 10 lbs.
- May require walking/standing to a significant degree
- May involve sitting with pushing and pulling of arm and/or leg controls

Medium

- Lifting 50 lbs. maximum
- Frequent lifting and/or carrying up to 20 lbs.
- May involve sitting with pushing and pulling or arm and/or leg controls.

Heavy

- Lifting 100 lbs. maximum
- Frequent lifting and/or carrying up to 50 lbs.

Very Heavy

- Occasional lifting in excess of 100 lbs.
- Frequent lifting and/or carrying excess of 50 lbs.