WORKSAFE TRAVAIL SÉCURITAIRE NB

Chiropractic Form 8-10

Provide this page to **WorkSafeNB**. Email securely through WorkSafeNB's MyServices or fax to **1 888 629-4722**.
If the page has been emailed or faxed, DO NOT mail the original.

PAGE 1: WORKSAFENB COPY

RESET FORM

☐ **First Chiropractic Report of Accident or Occupational Disease** ☐ **Chiropractic Progress Report**

PATIENT

Medicare #: | Claim #: | Visit date: YYYY-MM-DD | Time: HH:MM ☐ AM ☐ PM

Last name: | First name: | ☐ Male ☐ Female ☐ X | Birthdate: YYYY-MM-DD

Address: | City/Town: | Province:

Postal code: | Phone (cell): | Phone (home/other): | Date of incident: YYYY-MM-DD

Employer: | Occupation:

CLINICAL REPORT

☐ Acute strain/sprain ☐ Repetitive strain injury
☐ Other injury/illness (examples: disc, fracture, psych. injury)
(please specify):

Concussion/mTBI, head injury with:
☐ Altered mental state ☐ Focal defect
☐ Amnesia ☐ LOC

Body part	Left	Right	Body part	Left	Right
Shoulder	☐	☐	Hand/Digit	☐	☐
Elbow	☐	☐	Hip/Thigh	☐	☐
Wrist	☐	☐	Knee	☐	☐
Forearm	☐	☐	Ankle/Foot	☐	☐

☐ Neck ☐ Upper back ☐ Lower back
☐ Other
(please specify):

Description of injury/illness, worker's symptoms and examination findings (include joint dysfunctions):

X-Ray:

If progress report:
Subjective progress: ☐ Improved ☐ Unchanged ☐ Regressed
Objective progress: ☐ Improved ☐ Unchanged ☐ Regressed
In addition, please attach any applicable clinic note(s)/chart(s).

Complicating factors:

Diagnosis (best working):

Recommendation(s): ☐ Specialist ☐ Physio ☐ OT assessment ☐ Imaging ☐ Other
Please specify:

Treatment
(plan/type/frequency):

EMPLOYER NOTE

Functional abilities **(provide page 2 to the patient)**:
☐ 1. Able to perform usual work duties.
☐ 2. Able/unable to perform work duties as detailed below. WorkSafeNB may arrange a formal assessment of functional abilities.
☐ 3. Case management to call for further detail.

Function	Able	Unable	Function	Able	Unable	Function	Able	Unable
Bend/Twist	☐	☐	Push/Pull	☐	☐	Upper extremities use	☐	☐
Climb	☐	☐	Sit	☐	☐	Motor vehicle use	☐	☐
Kneel	☐	☐	Stand	☐	☐	Public transportation use	☐	☐
Lift	☐	☐	Walk	☐	☐	Heavy equipment operation	☐	☐

Valid for _____ days (maximum 14 days without additional review)

Other limitations/modifications/additional comments:

PROVIDER

WorkSafeNB payee #: _____
Provider address: _____
Town/City: _____ Province: _____
Postal code: _____ Phone: _____

Subsection 41(10) of the *Workers' Compensation Act* authorizes you to release this information. I confirm that by completing this form, I believe the injury or illness to be consistent with the workplace accident or exposure, and in submitting this document, I attest to the accuracy of the information and the adherence to best practice standards. I understand that payment is dependent on legible completion of form.

	Date of service	Description of service	Fee
1			
2			
3			
4			
5			
6			
7			
8			
		Total	0

Name _____ Signature _____ Date _____ YYYY-MM-DD

WorkSafe Travail sécuritaire NB

Chiropractic Form 8-10

PAGE 2: PATIENT/EMPLOYER COPY

Give this page to the **patient** to provide to their employer.

☐ **First Chiropractic Report of Accident or Occupational Disease** ☐ **Chiropractic Progress Report**

PATIENT

Claim #: Visit date: YYYY-MM-DD Time: HH:MM ☐ AM ☐ PM

Last name: First name: ☐ Male ☐ Female ☐ X Birthdate: YYYY-MM-DD

Address: City/Town: Province:

Postal code: Phone (cell): Phone (home/other): Date of incident: YYYY-MM-DD

Employer: Occupation:

WORKER GUIDANCE

You are here!

Hurt at work? Now what?

It can be overwhelming to know what to do when you've been hurt at work. In such times, it's good to know you have a team of support. This *Chiropractic Form 8-10* (page 2) gets your recovery off to a good start. Please provide this to your supervisor or manager as soon as possible so they are aware of your work capabilities at this time. See the steps for reporting a workplace injury, as well as your option for applying for workers' compensation benefits.

Learn more about workers' compensation and the application process at **worksafenb.ca**.

Haven't told your employer about your injury or illness yet? Do it as soon as you can!

Tell your employer.

Let your employer know that you've been hurt at work as soon as possible. They can help you get the help you need. They must also help protect others from getting hurt in the workplace.

Get health care, if needed.

Give your health care provider as much detail as possible to help them help you. Let them know you were hurt at the workplace.

Give the *Chiropractic Form 8-10* (page 2) to your employer.

This page provides valuable information about your work capabilities to help you and your employer develop next steps.

If you wish to apply for workers' compensation benefits, file an *Application for Workers' Compensation Benefits*.

Benefits can include treatment, wage replacement or both. Open the form at worksafenb.ca.

Clinical information has been removed from this section in compliance with the *Personal Health Information Privacy and Access Act*.

EMPLOYER NOTE

Functional abilities

☐ 1. Able to perform usual work duties.

☐ 2. Able/unable to perform work duties as detailed below. WorkSafeNB may arrange a formal assessment of functional abilities.

☐ 3. Case management to call for further detail.

Function	Able	Unable	Function	Able	Unable	Function	Able	Unable
Bend/Twist	☐	☐	Push/Pull	☐	☐	Upper extremities use	☐	☐
Climb	☐	☐	Sit	☐	☐	Motor vehicle use	☐	☐
Kneel	☐	☐	Stand	☐	☐	Public transportation use	☐	☐
Lift	☐	☐	Walk	☐	☐	Heavy equipment operation	☐	☐

Valid for _____ days (maximum 14 days without additional review)

Other limitations/modifications/additional comments:

PROVIDER

Name _____ Signature _____ Date YYYY-MM-DD _____