WORKSAFE TRAVAIL SÉCURITAIRE NB

Form 10C
GUIDELINES FOR THE COMPLETION OF FORM 10C, CHIROPRACTOR'S PROGRESS REPORT

DEFINITIONS FOR RESTRICTIONS AND LIMITATIONS

1. Work Restriction: Something a **patient can do, but should not do.**
2. Work Limitation: What a patient is **not physically able to do.**

1. RETURN TO WORK / LIMITATIONS

Employers have a duty to accommodate injured workers. Employees have a duty to accept any reasonable offer of accommodation. If your patient cannot return to full pre-accident duties, please check the appropriate restriction(s) / limitation(s), provide any specifics in the comments section, provide an estimate of the duration of the restriction(s) / limitation(s), and give the bottom copy of the form to your patient to take back to their employer. If you are unsure of your patient's job demands or how the condition may affect your patient's job, the Commission encourages you to speak with your patient's employer or WorkSafeNB case manager. A work-related functional evaluation or job task analysis may help you match your patient's functional capabilities with job demands

2. GENERAL COMMENTS

This form includes a copy for the employer that should help your patient's employer provide modified duties or temporary alternate work if you identify a physical limitation. **You must give the bottom copy of the form to the patient at the time of the visit or make arrangements for the patient to return and pick it up.**

The form must be completed to process the claim and your account.

The form should be faxed to WorkSafe NB at **1 888 629-4722 within five business days.** Keep the original in your chart.

Additional information may be obtained from the following offices:

WorkSafeNB

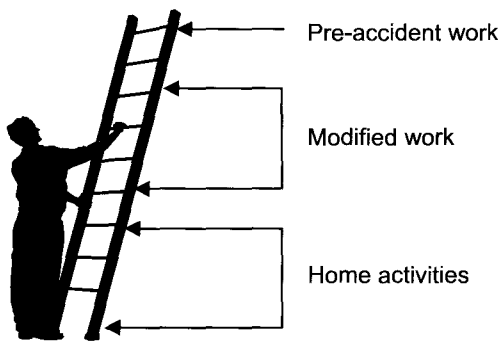
Saint John office
1 Portland Street
PO Box 160
Saint John, NB E2L 3X9
Telephone: 506 632-2200
Toll-Free: 1 800 222-9775

Regional Offices:

Bathurst office	**Telephone: 506 547-7300**
Grand Falls office	**Telephone: 506 475-2550**
Dieppe office	**Telephone: 506 867-0525**
Saint John office	**Telephone: 506 632-2200**
Toll-Free number for all regions:	**1 800 222-9775**

Toll-Free Physician Enquiry Line can be used by chiropractors to contact WorkSafeNB 1 877 647-0777

Functional Ladder



Functional Expectations Roadmap

How far down the functional ladder one falls after an injury depends on the nature and severity of the injury.

Home activities includes: basic (e.g., personal hygiene, dressing and eating); Activities of Daily Living (ADLs); Instrumental ADLs (e.g., making meals, simple chores around the home, getting around town, banking, getting groceries); social and recreational activities.

Modified work includes: gradual return, ergonomic modification(s), duties modification, alternate work or transitional work. Gradual and transitional return to work should be limited to under 10 weeks.

In the Functional Level boxes, select the highest functional level.

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Form 10C
Chiropractor's Progress Report

Section 41 (10) of the *Workers' Compensation Act* authorizes you to release this information

Please FAX this form TOLL-FREE IMMEDIATELY to: **1 888 629-4722**
If the form has been faxed, it is not necessary to mail the original.

Medicare No. or Social Insurance No. _____ WorkSafeNB Claim No. _____

Last Name of Worker _____ Given Name(s) _____ ☐ Male ☐ Female

Address _____ City _____ Province _____ Postal Code _____

Worker's Telephone No. _____

Name of Employer _____ Date of Accident _____ (Y) _____ (M) _____ (D)

Date of Consultation _____ (Y) _____ (M) _____ (D)

FINDINGS

1. Diagnosis _____

☐ Back ☐ Upper ☐ Lower	☐ Neck	☐ Shoulder ☐ Left ☐ Right	☐ Knee ☐ Left ☐ Right	☐ Other _____ ☐ Left ☐ Right

2. Worker's symptoms ☐ No change **OR** _____
3. Objective findings ☐ No change **OR** _____
4. X-rays? ☐ Yes ☐ No _____
5. Significant factors / complications ☐ As before **OR** elaborate _____
6.

Current Level of Function	→	Next Visit: Functional Expectation	→	Functional Destination
☐ full job duties ☐ modified work / hours ☐ home activities		☐ no follow-up planned ☐ full job duties ☐ modified work / hours ☐ home activities		☐ full return to work ☐ modified / transitional work within _____ weeks

TREATMENT (Acute care is 2/week or more. Maintenance care is 1/week or less.)

7. Technique _____

Plan for further treatment _____

Frequency _____

Referral (whom, profession or test) _____

EMPLOYER NOTE

_____ was seen by me on _____.

He/She can return to full duties. ☐ Yes ☐ No, but...
He/She can safely perform normal duties **EXCEPT FOR**:

☐ Some upper extremity limitation/restriction	☐ Lifting
☐ Some lower extremity limitation/restriction	☐ Kneeling
☐ Bending, twisting	☐ Prolonged standing
☐ Prolonged walking	☐ Prolonged sitting

Please expand on limitations/restrictions: _____

CHIROPRACTOR'S ACCOUNT

Name *(or stamp)* _____

Address _____

Postal Code _____ WorkSafeNB Payee # _____

Date of Service	Description of Service	Fee
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	TOTAL	

Name _____ Signature _____ Date _____ Tel: _____

Comments: _____

IMPORTANT: You must give the last page to the worker to return to their employer.

EMPLOYER NOTE

_____ was seen by me on _____.

He/She can return to full duties. ☐ Yes ☐ No, but...
He/She can safely perform normal duties EXCEPT FOR:

☐ Some upper extremity limitation/restriction	☐ Lifting
☐ Some lower extremity limitation/restriction	☐ Kneeling
☐ Bending, twisting	☐ Prolonged standing
☐ Prolonged walking	☐ Prolonged sitting

Please expand on limitations/restrictions: _____

Name _____ Signature _____ Date _____ Tel: _____

IMPORTANT: It is the responsibility of the worker to return this form to his/her employer.