WORKSAFE TRAVAIL SÉCURITAIRE NB

Need help? Scan the QR code, right, for more information or call 1 877 647-0777.
worksafenb.ca/form-8-10

Medical Form 8-10

Please email this form through MyServices or fax to **1 888 629-4722**. If the form has been emailed or faxed, DO NOT mail the original.

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

PATIENT

Medicare #: Claim #: Visit date: YYYY-MM-DD Time: 00:00 AM/PM

Last name: First name: ☐ Male ☐ Female DOB: YYYY-MM-DD

Address: City/Town: Province:

Postal code: Phone: Date of incident: YYYY-MM-DD

Employer: Occupation:

PROVIDER

☐ Acute strain/sprain ☐ Fracture
☐ Repetitive strain injury
☐ Other injury/illness (example: laceration or psych. injury) (please specify):

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

Other or previous injury contributing to delayed recovery:

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 anatomical structure (not captured above) (please specify):

Description of occupational injury/illness (please provide objective/subjective findings):

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

Diagnosis (best working):

Diagnostics ordered: ☐ CT ☐ EMG ☐ MRI ☐ X-ray
Other: Facility:

Treatment plan includes: ☐ Chiro ☐ Physio Specialist referral Dr. Rx:

EMPLOYER NOTE

Physician functional abilities recommendations **(please provide Page 2 of this form to patient)**:
☐ 1. Medically able to perform usual work duties.
☐ 2. Medically able/unable to perform duties as detailed below. WorkSafeNB may arrange a formal assessment of functional abilities.

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 2 weeks without additional review)

Other limitations (reduced hours, limitations due to medication, etc.):

PROVIDER ACCOUNT

Health care provider type:
☐ Emergency physician
☐ Family physician
☐ Nurse practitioner
☐ Speciality physician
☐ Walk-in clinic

WorkSafeNB payee #:
Provider office service code(s):

Provider address:
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.

Print name Signature

IMPORTANT: YOU MUST GIVE PAGE 2 TO THE PATIENT TO PROVIDE TO THEIR EMPLOYER.

WORKSAFE
TRAVAIL SÉCURITAIRE NB

Need help? Scan the QR code, right, for more information or call 1 877 647-0777.
worksafenb.ca/form-8-10

Medical Form 8-10

☐ First Medical Report of Accident or Occupational Disease ☐ Medical Progress Report

PATIENT

Claim #: Visit date: YYYY-MM-DD Time: 00:00 AM/PM

Last name: First name: ☐ Male ☐ Female DOB: YYYY-MM-DD

Address: City/Town: Province:

Postal code: Phone: Date of incident: YYYY-MM-DD

Employer: Occupation:

Medical information has been removed from the employer's copy in compliance with the *Personal Health Information Privacy and Access Act*.

EMPLOYER NOTE

Physician functional abilities recommendations:

☐ 1. Medically able to perform usual work duties.

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

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 2 weeks without additional review)

Other limitations (reduced hours, limitations due to medication, etc.):

PROVIDER ACCOUNT

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.

Print name ______________________ Signature ______________________

IMPORTANT: YOU MUST GIVE THIS PAGE TO THE PATIENT TO PROVIDE TO THEIR EMPLOYER.