WORK SAFE BC

(See reverse of form for submission criteria.)

RESET

Physician's Report

SELECT ONE ONLY: ☐ **Physician's First Report (F8)** ☐ **The worker's condition or treatment has changed (F11)**

(required if you suspect the worker may be disabled beyond the day of injury or if the claim is for a hernia, back condition, shoulder or knee strain/sprain, occupational disease, or mental disorder)

(required if the worker's condition or treatment has changed since last report or if the worker is ready for return to work)

Date of service (yyyy-mm-dd)	Date of birth (yyyy-mm-dd)	WorkSafeBC claim number
Employer's name	Worker's last name	
Employer's telephone number (must include area code)	First name	Middle initial / Gender
Operating location address	Mailing address (include postal code)	
Date of injury or when patient was first treated for this condition (yyyy-mm-dd)	Worker's contact telephone number (must include area code)	
Who rendered first treatment?	Worker's personal health number (BC Services Card/CareCard)	

8/11

Are you the worker's regular practitioner? ☐ YES ☐ NO

If YES, how long has the worker been your patient? ☐ 0–6 months ☐ 7–12 months ☐ > 1 year

Are there prior or other problems affecting injury, recovery, and disability?

From injury or last report, has the worker been disabled from work? ☐ YES ☐ NO If YES, as of what date? (yyyy-mm-dd)

Injury codes and descriptions

Diagnosis (text)		
CSA BP/AP (code)	CSA NOI (code)	ICD9 (code)

Clinical information

What happened? Subject Sx, examination, investigations, treatments/meds, specialists consult?

Return-to-work planning

Is the worker now medically capable of working full duties, full time? ☐ YES ☐ NO

If NO, what are the current physical and/or psychological restrictions?

Estimated time before the worker will be able to return to the workplace in any capacity

☐ Currently at work ☐ 1–6 days ☐ 7–13 days ☐ 14–20 days ☐ > 20 days

If appropriate, is the worker now ready for a rehabilitation program? ☐ YES ☐ NO If YES, select ☐ WCP or ☐ Other

Do you wish to consult with a WorkSafeBC physician or nurse advisor? ☐ YES ☐ NO

If possible, please estimate date of maximal medical recovery (full recovery or best possible recovery) (yyyy-mm-dd)

Payee number	Practitioner number
Payee name	Practitioner name

Additional information can be recorded on form 8/11 Addendum, Practitioner's Report/Additional Information