

Medical Report Eye Injuries

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN IT TO THE ADDRESS ON THE REVERSE

WSCC Claim Number	Health Care Provider (please print)
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Worker Information

Last Name		First Name							
Mailing Address (include postal code)			Community			Telephone (include area code)			
Residential Address				Date of Birth		YY	MM	DD	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Employer's Name				Social Insurance Number			Worker's Occupation		
Part of Body Injured			Date of Injury		YY	MM	DD	Date of Exam YY MM DD	

1. Would you like a WSCC Doctor to contact you? <input type="checkbox"/> Yes <input type="checkbox"/> No										
2. Who rendered first treatment?				3. Date you first treated this patient YY MM DD						
4. Which eye was injured? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both										
5. Visual Acuity (at your first examination and before the treatment)					Right Eye		Left Eye			
6. What did the worker say caused the injury?										
7. Findings at the time of your examination (indicate on the diagram below, the location and extent of injury after fluorescein)										
8. Treatment										
9. Is there any evidence of previous disease or injury in either eye? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give particulars										
10. Do you expect any complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain										
11. Is permanent disability probable? <input type="checkbox"/> Yes <input type="checkbox"/> No										
12. Current work ability <input type="checkbox"/> Fit for regular work duties <input type="checkbox"/> Unfit for regular work duties										
								Start date for the return to regular work duties		
								YY	MM	DD
<input type="checkbox"/> Capable of modified duties (see categories on back page)										
<input type="checkbox"/> Limited <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy										
Duration of modified duties <input type="checkbox"/> 1-7 days <input type="checkbox"/> 8-14 days <input type="checkbox"/> 15-21 days <input type="checkbox"/> more										
								Start date for modified duties		
								YY	MM	DD
13. Is hospital care required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name of hospital										

Health Care Professional's Signature _____ Date _____
 I hereby certify that the above is a correct statement of services personally rendered by me.

Worker's Name

Claim Number

Health Care Provider Information

Name of Health Care Provider (please print)	WSCC Supplier Billing Number			
Telephone (include area code)	Fee Code _____	Fee Submitted _____		
Address (include postal code)	Fee Code _____	Fee Submitted _____		
	Report Form Fee _____	Fee Submitted _____		
	TOTAL \$ _____			
	Date of Exam	YY	MM	DD

Health Care Provider's Signature _____ Date _____

I hereby certify that the above is a correct statement of services personally rendered by me.

NOTE TO SUPPLIERS:

We make payments on original invoices only. Faxed invoices or copies of invoices will not be paid.

RESPONSIBILITY OF HEALTH CARE PROVIDER

Excerpts from the Nunavut & NWT *Workers' Compensation Acts*

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|--------------------------------|---------|--|
| Report by health care provider | 25. (1) | A health care provider who examines or treats a worker under this Act shall submit a report to the Commission. |
| Timing and contents of report | (2) | The report must be submitted within three days after the examination or treatment, and must contain the information required by the Commission. |
| Duty of health care facility | (3) | If a health care facility employs the health care provider referred to in subsection (1), the health care facility is responsible for ensuring that the report is submitted in accordance with this section. |
| Provision of information | 30. | The Commission may require a claimant, an employer or a health care provider to provide any information that it considers necessary for it to determine a claim for compensation. |

Excerpt from the Nunavut & NWT *Workers' Compensation General Regulations*

- 7.2 A health care provider who fails to provide information required under section 30 of the Acts is liable under subsection 141(2) to a penalty of \$250.

WORK CAPABILITIES

Reference: *National Occupational Classification*

Limited

Work activities involve handling loads up to 5 kg.

Examples:

- examining and analyzing financial information
- selling insurance to clients
- conducting economic and feasibility studies

Light

Work activities involve handling loads of 5 kg, but less than 10 kg.

Examples:

- repairing soles, heels and other parts of footwear
- filing materials in drawers, cabinets and storage boxes
- preparing and cooking meals

Medium

Work activities involve handling loads between 10 kg and 20 kg.

Examples:

- setting up and operating finishing machines or finishing furniture by hand
- measuring, cutting and applying wallpaper to walls
- adjusting, replacing or repairing mechanical or electrical components using hand tools and equipment

Heavy

Work activities involve handling loads of more than 20 kg.

Examples:

- operating and maintaining deck equipment and performing other deck duties aboard ships
- shovelling cement and other materials into cement mixers and performing other activities to assist in the maintenance and repair of roads
- measuring, cutting and fitting drywall sheets for installation on walls and ceilings

For Office Use Only

Supplier	RFP#	Billing Code	Entered By	Date	Authorized By	Date
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Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677

or

Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501