

# Hand Arm Vibration (HAV) Syndrome Assessment Form

COMPLETE THIS FORM AND RETURN TO ADDRESS LISTED BELOW. PLEASE PRINT.

WSSC 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"/> Male <input type="checkbox"/> Female	
Employer's Name:		Worker's Occupation:	

<p><b>PERIPHERAL VASCULAR ASSESSMENT</b></p> <p><b>Symptoms?</b> (vascular reactivity, timing, duration, anatomic sites)</p> <p><b>Clinical Findings?</b> (pulses, colour, trophic changes, edema)</p>	<p><b>RELEVANT MEDICAL HISTORY</b></p> <p>1) Concurrent disease(s) with vascular, neurological or musculo-skeletal sequelae?</p>
	<p>2) Tobacco use? Current or past?</p>
<p><b>PERIPHERAL NEUROLOGICAL ASSESSMENT</b></p> <p><b>Symptoms?</b> (quality, timing, duration, anatomic distribution)</p> <p><b>Clinical Findings?</b> (sensory and motor testing, reflexes)</p>	<p>3) Current medication and/or herbal remedies?</p>
	<p>4) Family history of Raynaud's Disorder?</p>
<p><b>EXTREMITY MUSCULO-SKELETAL/SKIN ASSESSMENT</b></p> <p><b>Symptoms?</b> (power, skin colour, temperature)</p> <p><b>Clinical Findings?</b> (ROM, atrophy, edema)</p>	<p>5) Vibration exposures in non-occupational settings?</p>

Worker's Name:	WSCC Claim Number:
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**Health Care Provider Information**

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

Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I hereby certify 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 and Northwest Territories *Workers' Compensation Acts*:

- |                                |         |  |
|--------------------------------|---------|--|
| 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 from 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 and Northwest Territories *Workers' Compensation General Regulations*:

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| 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. |
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**FOR OFFICE USE ONLY**

Supplier:	RFP#:	Billing Code:	Entered By:	Date:	Authorized By	Date:
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