

# C829 HOSPITAL HAND CLINIC ASSESSMENT REPORT

Box 2415  
Edmonton AB T5J 2S5  
Fax (780) 427-5863  
1-800-661-1993

WCB Claim Number		
Clinic Billing Number	Clinic Name	Personal Health Number
Worker's Surname	First Name	Initial
Date of Birth		(Year / Month / Day)
Address Street		City/Town Province
Postal Code	Telephone Number	Occupation N O C Code

If yes, specify Fractures: <input type="checkbox"/> Yes <input type="checkbox"/> No Amputations: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis  Dominant Hand <input type="checkbox"/> Left <input type="checkbox"/> Right
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Strength	R	AROM/PROM	L	Digits: Injured R or L AROM PROM (EX / FL)							
				D2	MP	PIP	DIP	TAM	TPM		
/	/	Shoulder: FF	/	D2	/	/	/				
/	/	ABD	/	D3	/	/	/				
/	/	IR	/	D4	/	/	/				
/	/	ER	/	D5	/	/	/				
/	/	Elbow: EX	/	Digits: Uninjured R or L AROM PROM (EX / FL)						TAM	TPM
/	/	FL	/	D2	/	/	/				
/	/	PRO	/	D3	/	/	/				
/	/	SUP	/	D4	/	/	/				
/	/	Wrist: EX	/	D5	/	/	/				
/	/	FL	/	D1	R MP (EX / FL)	R IP (EX / FL)	TROM	L MP (EX / FL)	L IP (EX / FL)	TROM	
/	/	UL DEV	/	AROM	/	/		/	/		
/	/	RAD DEV	/	PROM	/	/		/	/		

Closure Patterns		CMC ABD R	CMC ABD L
Flat Fist		CMC EXT R	CMC EXT L
Hook		Opposition: R	L
Full Fist		Edema/Volumeter: R	L

Comments / Observation:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

VAS /10 (Describe)  
 \_\_\_\_\_

Circumference	R/L (cm)	D1	D2	D3	D4	D5	
		/	/	/	/	/	
		/	/	/	/	/	
Strength:		R (kg)		AV.	L (kg)		Av.
Grip - Jamar (5 Positions)	1						
	2						
	3						
	4						
	5						
Key							
Tripod							
Tip							

ADL / Function:  
 \_\_\_\_\_

