WCB Workers' Compensation Board Alberta

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C914
MEDICATION MANAGEMENT REPORT

	Claim Number
	Personal Health Number
Worker's *(Surname)* *(First Name)* *(Initial)*	Date of Birth *(Year/Month/Day)*

Physician's Name	Telephone Number	**WCB Billing Number**	**Contract ID:**
Date of Injury *(Year/Month/Day)*	Part of body	Date of Examination *(Year/Month/Day)*	

Diagnosis					Health Service Code	Modifiers	Calls	Encounters
Diagnostic Code	Diagnostic Code	Diagnostic Code	Location	Skill Code	Health Service Code	Modifiers	Calls	Encounters

Current complaints:

Objective findings:

Current medications and dosages (including new prescriptions).

For what diagnosis are you prescribing opioids?

Are this patient's limitations due to opioid medication? ☐ Yes ☐ No ☐ Other If yes, explain.

Provide your own clinical estimate of your patient's level of function at this visit (check your numerical estimate).
0 = *severe impact on function at home and work* 10 = *return to pre-injury functional level* ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐ 9 ☐10

Has there been overall improvement in the patient's **function** since opioids were first used?
☐ Yes, Describe improvement:
☐ No, opioid regimen will be adjusted (see below) ☐ No, opioid will be discontinued (see treatment below) ☐ No, other (see below)

If function is not improving, explain rationale for continuing opioid analgesics.

What is your treatment plan to improve the patient's function? (include further investigation / consultation).

Provide the patient's estimate of average pain severity in the last week (check the numerical estimate).
0 = *no pain at all* 10 = *persistent severe pain* Pain Scale ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐ 9 ☐10

Has there been overall improvement in the patient's **pain** since opioids were first used?
☐ Yes ☐ No, opioid regimen will be adjusted (see Comments) ☐ No, opioid will be discontinued (see Comments) ☐ No, other (see Comments)
Comments:

Request for WCB resources (*Mark with an "X". The WCB will contact you*).
☐ Contact with WCB Case Manager ☐ Work Assessment Centre Referral ☐ Independent Medical Examination ☐ Contact with WCB Physician

Is injury preventing patient from performing date of accident work? ☐ Yes ☐ No	Any permanent impairment anticipated? ☐ Yes ☐ No	Estimated date of return to pre-accident level *(Year/Month/Day)*
Can "modified or alternate" work be performed? ☐ Yes ☐ No	Describe work capability ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy	
Any work restrictions? ☐ Yes ☐ No	Describe:	

Next follow up visit: *(Year/Month/Day)*	Physician's Signature	Date: *(Year/Month/Day)*

This document may be examined by any person with direct interest in the claim that is under review.