



ACUPUNCTURE FIRST REPORT

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

Claim Number

Personal Health Number

Patient's Surname First Name Initial Date of Birth (Year / Month / Day)

Address Street City/Town Province

Postal Code Telephone Number Date of Accident (Year / Month / Day) Is the patient working? Yes No

Employer's Name Telephone Number

Address Street City/Town Postal Code

1. Referring Physician: (If applicable) Date of Referral (Year / Month / Day)

2. Diagnoses: Date of Examination (Year / Month / Day)

3. Patient's Complaints (nature and site) Level of pain 1 5 10
Low High

4. Objective Findings (Including restrictive movement and functionality): Acute Chronic

5. Treatment Provided:
 Acupuncture Herbs Cups Moxabustion GUA SHA Electro Acupuncture
 Plum Blossom TDP Lamp TUI NA Other Describe: _____

6. Has the worker returned to work? If yes, date (Year) (Month) (Day) Yes No Part-Time Modified or Alternate work Full Time

7. Can the worker return to pre-accident employment? Yes No If No, why?

8. Do you wish a Case Manager to call? Yes No

9. Referral to other Health Care Provider? Yes No Specialty Area

Acupuncturist's Name and Address to whom fee is payable: (please print) Provider's Signature:
Clinic Name:

Billing Number. (If applicable) Date (Year / Month / Day) Telephone Number

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.