Workers' Compensation Board
Alberta

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? ☐ Yes ☐ No If yes, date *(Year)* *(Month)* *(Day)* ☐ 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.