wcb Workers' Compensation Board – Alberta
P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: 780-427-5863
1-800-661-1993

M007
ACUPUNCTURE SERVICES FIRST REPORT

Please print clearly or type.

			WCB Claim Number
Surname	First Name and Initial		Date of Birth *(yyyy/mm/dd)*
Address	City/Town	Province	Postal Code
Telephone Number			Date of Accident

Referring Physician	Date of Referral
Diagnoses	Date of Examination

Complaints *(nature and site)*

Level of Pain

0 5 10

NONE ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ HIGH

☐ *If this is for a psychology injury, please rate the level of anxiety above*

Objective Findings: ☐ Acute ☐ Chronic

Treatment Provided:

☐ Acupuncture ☐ Cups ☐ Moxabustion ☐ GUA/SHA ☐ Electro Acupuncture ☐ TDP Lamp

☐ Other (*describe*):

Has the worker returned to work? ☐ Yes ☐ No

If yes, please provide a date: _____ ☐ Part-time ☐ Modified or Alternate Work ☐ Fulltime

Can the worker return to pre-accident employment? ☐ Yes ☐ No

If no, describe work restrictions ☐ Temporary ☐ Permanent ☐ Duration: _____

Would you like a case conference with the claim owner? ☐ Yes ☐ No	**Referral to other Health Care Provider?** ☐ Yes ☐ No	**Specialty Area**

Name and Address to Whom Fee is Payable (print)	Signature	Date *(yyyy/mm/dd)*
	Clinic Name	
WCB Billing Number:	Telephone Number	Fax Number *(if no fax number please provide email address)*

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.
CORRECTIONS MUST BE SUBMITTED WITHIN 2 MONTHS OF BEING NOTIFIED BY WCB OF AN ERROR.