Workers' Compensation Board – Alberta
P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: 780-427-5863
1-800-661-1993
780-498-3226 for extension requests

M007A
ACUPUNCTURE SERVICES
☐ PROGRESS ☐ DISCHARGE 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	Date of Examination	

Request for further treatment? ☐ Yes ☐ No	**If yes, number of treatments required?**	**Referral to other Health Care Provider** ☐ Yes ☐ No **Specialty Area:**

Subjective Complaints:

Level of Pain
1 5 10
LOW ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ HIGH
☐ *If this is for a psychological injury, please rate the level of anxiety above*

Length of time pain free after treatment
Days

Objective Findings *(sleep, pain medication, progress at work/home):*

Treatment Provided:
☐ Acupuncture ☐ Cups ☐ Moxabustion ☐ GUA/SHA ☐ Electro Acupuncture ☐ TDP Lamp
☐ Other (*describe*):

Positive outcome of treatment as reported by claimant:

Complications:

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: _____

Do you wish a Case Manager to call? ☐ Yes ☐ No	**Total number of treatments?**	**Dates of treatments:**

Name and Address to Whom Fee is Payable (print)	Signature	Date *(yyyy/mm/dd)*
	Print 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.