Workers' Compensation Board
Alberta

ACUPUNCTURE PROGRESS ☐ REPORT
DISCHARGE ☐

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

1. Subjective Complaints: | Date of Examination *(Year / Month / Day)*

Level of pain 1 5 10 (Low – High)

Length of time pain free after treatment

2. Objective findings:

Treatment Provided:

☐ Acupuncture ☐ Herbs ☐ Cups ☐ Moxabustion ☐ GUA SHA ☐ Electro Acupuncture

☐ Plum Blossom ☐ TDP Lamp ☐ TUI NA ☐ Other Describe:

3. Positive outcome of treatment as reported by patient:

4. Complications:

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

6. Can the worker return to pre-accident employment? ☐ Yes ☐ No If no, describe work restrictions: ☐ Temporary ☐ Permanent Duration:

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

8. Total number of treatments: | Dates of Treatments:

9. Request for further treatment? ☐ Yes ☐ No If yes, number of treatments required:

10. 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.