Jan. 2019

WorkplaceNL

MAIL FORM TO:
P.O. Box 9000
St. John's, NL A1A 3B8
FAX FORM TO:
f 709.738.1479

CALL US AT:
t 709.778.1000
t 1.800.563.9000
TOLL FREE FAX:
f 1.800.553.5119

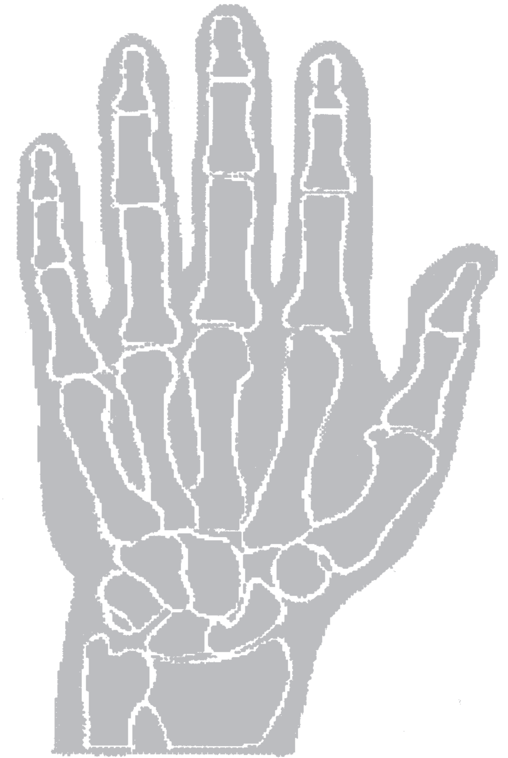
DROP OFF IN PERSON:
146-148 Forest Road
P.O. Box 9000
St. John's, NL, A1A 3B8
VISIT: workplacenl.ca

Claim No.	FORM 53
Date of Injury YY MM DD	

Please ask your treating health care provider to complete this form and return it to WorkplaceNL.

HAND FORM

CLAIMANT'S NAME		
ADDRESS		
CITY OR TOWN	PROV.	POSTAL CODE
TELEPHONE NO.	SOCIAL INSURANCE NO.	
DATE OF BIRTH YY MM DD	PATIENT'S MCP NUMBER	



Which hand is injured?________________________________

Which hand was dominant?________________________________

Previous defect of affected hand?________________________________

— **AMPUTATION:** Mark by straight line(s) on the diagram, the site and direction of any amputation arising from the injury.

○ **RESTRICTION**: Mark a circle over the joint(s) which have permanently impaired restriction of motion as a result of the injury.

X **ANKYLOSIS**: Mark an X over the joint(s) permanently ankylosed as a result of the injury.

FLEXION and EXTENSION of IMPAIRED JOINTS:

For each joint permanently damaged by the injury, record in degrees, in the table below:

1. the position of utmost flexion, and
2. the position of utmost extension (in terms of lack of full extension).

FINGER	JOINT: normal flexion:	DIP 70^{0}	PIP 100^{0}	MCP 90^{0}
LITTLE	degrees of utmost flexion:			
	lack of extension:			
RING	degrees of utmost flexion:			
	lack of extension:			
MIDDLE	degrees of utmost flexion:			
	lack of extension:			
INDEX	degrees of utmost flexion:			
	lack of extension:			

	JOINT	IP	MCP
THUMB	degrees of utmost flexion:		
	lack of extension:		

Detail any restrictions of thumb:

ADDUCTION: ____________________

ABDUCTION: ____________________

OPPOSITION: ____________________

Detail any other impairment as a result of the compensable injury (i.e., cold sensitivity, altered sensation, swelling, tissue loss/deformity, etc.)

____

____

What further improvement do you expect?________________________________

____

If any, when will maximum recovery expect to be reached________________________________

Other comments?________________________________

I certify that this a complete and accurate report.

HEALTH CARE PROVIDER'S SIGNATURE:________________________________

PRINT NAME:________________________________ DATE: ________________________________