WorkplaceNL

SEND BY FAX ONLY
f 709.738.1479
f 1.866.553.5119

CONTACT US AT:
t 709.778.1000
t 1.800.563.9000

VISIT US AT:
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Instructions for Completing Physician's Report Form MD

A physician would complete this report for:

1. New injuries – The physician or worker believes the injury is work-related.
2. Recurrences – The injury may be a recurrence of a previous work-related injury.
3. Progress reporting – When there is a significant change in the worker's: (1) condition; (2) treatment; or (3) return-to-work status.

On the day of the visit:

Provide the employer's copy of the form MD to the injured worker, who will then give it to the employer. Only sections outlined in red are visible on the employer's copy.

Complete and legible reporting:

- Reporting fees will not be paid for incomplete or illegible reports.
- Please do not use a stamp for any information including physician's name, contact information or billing number. Stamps are not permitted as this is a triplicate form. Information provided by stamp will not be visible on the worker and employer copies of the form. Forms using stamps will be considered illegible.

Section B - Specific Information for Parts of Body Injured:

- It is not necessary to provide the *Mechanism of Injury* information on reports subsequent to the initial report unless there is a change in the information provided or additional information is available.
- Coding is used in this section as outlined on the reverse of this sheet. Only one code box should be used for each code entered, regardless if the code has one or two digits (see example below).
- First, enter codes for *Part(s) of Body* and whether the injury pertains to the Left, Right or Center of the specified body part(s), if applicable. If the code for the *Part of Body* is not on the code sheet, enter the code for *Other* and identify the specific body part in the space below the code.
- For each *Part of Body*, enter coding, as applicable, for Subjective Reports, Objective Findings, Diagnoses, Treatments, Investigations*, and Assistive Devices*. When outlining the *Examination* and *Treatment Plan,* including all applicable codes is important.
- If the Subjective Report, Objective Finding, Diagnosis, Treatment, Investigation and/or Assistive Device is not included on the code sheet, enter the code for *Other*. When using *Other* codes, also enter the *Other* code number and provide details for that code in the Additional Comments box (box 8).
- The *Update Status* boxes are used when completing progress reports. They are intended to provide updates on Subjective Reports and Objective Findings from the previous visit. The *Update Status* is not required for initial reports of injury.

**Note:* *The Investigations category is only intended for referrals being made at the time of this visit. Recommendations for assistive devices may also require completion of a Health Care Devices and Supplies Prescription form.*

Section B Example

SECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED

6 Mechanism of injury / incident:

Same as previously reported on the initial report.

7 Use codes from code sheet
use more than one code where necessary

Part of Body Code		Examination: Subjective Reports (1 2 3 4)	Examination: Objective Findings (1 2 3 4)	Examination: Diagnoses (1 2 3)	Treatment plan: Treatments (1 2)	Treatment plan: Investigations (1 2)	Treatment plan: Assist. Devices (1 2)
i. 22 ☐ Left ☐ Right ☐ Centre		11	1 10 92	27	20		
Other:	Update Status	C	C C				
ii. 90 ☐ Left ☐ Right ☐ Centre			29	1			
Other: Nose	Update Status		A				
iii. ☐ Left ☐ Right ☐ Centre							
Other:	Update Status						

Did this injury aggravate a prior health issue?
☐ Yes ☑ No ☐ Don't know

Are there other issues affecting the worker's injury, recovery and / or disability?
☐ Yes ☑ No ☐ Don't know

If yes to either of the above please specify in Box 8.

8 Additional Comments - *or* - If you use any of the "other" codes above (except Part of Body), indicate the code # and provide details.

92 - negative bowstring test
Decreased ROM - F.F. 40°, Ext. 10° (L)+(R) Rotation (W) (L)+(R) Flexion (W)

Points to note:

- The second *Part of Body* in this example was not included on the code sheet. Therefore, code *90* is entered for *Other* and *Nose* is written in the text box immediately below the *Part of Body* code.
- Under Objective Findings for the first *Part of Body*, code 10 is used for *decreased range of motion*. The details related to the decreased ROM are documented in the Additional Comments box.
- Also under Objective Findings for the first *Part of Body*, code *92* is entered for *Other* and *92 - negative bowstring test* is written in the Additional Comments box to specify the details of the *Other* code.
- No Update Status is provided for the negative bowstring test as this finding had not been previously reported.

Section C Specific Information for All Diagnoses (pertaining to Section B):

- Subsection 12 only applies to medications prescribed for the work injury and not medications related to non-work related injuries or illnesses.

PHYSICIAN'S FORM MD MUST BE FAXED ONLY

Toll free fax
1.866.553.5119

This information is collected under the authority of the *Workplace Health, Safety and Compensation Act* to determine entitlement to benefits and manage the injured worker's claim. If you have any questions about this, please contact WorkplaceNL's Access to Information and Protection of Privacy (ATIPP) Coordinator at 1.800.563.9000.

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MD, 8/10c and PR Code Sheet

Effective Date: December 2017

Part of Body

1 Abdomen
2 Ankle
3 Arm
4 Brain
5 Cervical region
6 Chest
7 Coccyx
8 Ear
9 Elbow
10 Eye
11 Face
12 Finger
13 Foot
14 Forearm
15 Groin
16 Hand
17 Head
18 Heel
19 Hip
20 Knee
21 Lower leg
22 Lumbar region
23 Lumbosacral region
24 Lung, airways
25 Pelvis
26 Ribs
27 Sacroiliac region
28 Shoulder
29 Thigh
30 Thoracic region
31 Thoracolumbar region
32 Toe
33 Wrist
90 Other*

* *Provide details in the Other box located under Part of Body*

Subjective Reports

1 Burning
2 Difficulty sitting
3 Difficulty standing
4 Difficulty walking
5 Dizziness
6 Headache
7 Interrupted sleep
8 Numbness
9 Limited weight bearing
10 Pain (mild)
11 Pain (moderate)
12 Pain (severe)
13 Pain radiating
14 Stiffness
15 Tenderness
16 Tingling
17 Weakness
88 No subjective reports
91 Other*

* *Provide details in the Additional Comments box*

Objective Findings

1 Abnormal gait
2 Abnormal reflexes
3 Abnormal sensation (dermatomal)
4 Abnormal sensation (non-dermatomal)
5 Atrophy
6 Bleeding
7 Bruising
8 Crepitus
9 Decreased air entry
10 Decreased range of motion **(Physician use only) (Provide details in box 8)**
11 Deformity
12 Hypermobility
13 Hypertonicity
14 Hypomobility
15 Hypotonicity
16 Infection
17 Joint effusion
18 Laceration
19 Leg length discrepancy
20 Level of conditioning (good)
21 Level of conditioning (fair)
22 Level of conditioning (poor)
23 Range of motion (100%)
24 Range of motion (≥75%)
25 Range of motion (≥50%)
26 Range of motion (≥25%)
27 Range of motion (<25%)

Physiotherapy and Chiropractic use only

28 Rash
29 Redness / discoloration
30 Scar
31 Sensory loss
32 Spasm
33 Straight leg raise (Negative)
34 Straight leg raise (60+)
35 Straight leg raise (30-60)
36 Straight leg raise (0-30)
37 Strength (5/5)
38 Strength (4/5)
39 Strength (3/5)
40 Strength (2/5)
41 Strength (1/5)
42 Swelling
43 Upper limb neural tension test (+ve)
44 Upper limb neural tension test (-ve)
45 Wasting
46 Weakness
47 Wheezing
89 No objective findings
92 Other*

* *Provide details in the Additional Comments box*

Update status to be added for follow up on Subjective Reports and Objective Findings.

A Resolution
B Significant improvement
C Moderate improvement
D Mild improvement
E No change
F Worsening

Diagnosis

1 Abrasion
2 Allergic reaction
3 Amputation
4 Asthma
5 Burn
6 Bursitis
7 Carpal tunnel syndrome
8 Chronic obstructive pulmonary disease
9 Contusion
10 Crush
11 Dermatitis
12 Disc injury
13 Dislocation
14 Epicondylitis
15 Fracture
16 Frozen shoulder
17 Hernia
18 Herniated disc
19 Infection
20 Inflammation
21 Laceration
22 Ligament sprain (1st)
23 Ligament sprain (2nd)
24 Ligament tear (3rd degree sprain)
25 Mechanical back pain
26 Meniscal tear
27 Muscle strain
28 Plantar fasciitis
29 Puncture
30 Radiculopathy
31 Repetitive strain
32 Rotator cuff impingement
33 Rotator cuff injury
34 Rotator cuff tear
35 Spinal cord injury
36 Spinal stenosis
37 Spondylolisthesis
38 Tendonitis
39 Tenosynovitis
40 Traumatic spondylolisthesis / lysis
93 Other*

* *Provide details in the Additional Comments box*

Treatments

1 Acupuncture
2 Casting
3 Chiropractic
4 Cold
5 Conditioning exercises
6 Core stability exercises
7 Education
8 Heat
9 Home exercises
10 IFC
11 Laser
12 Manipulations
13 Massage
14 Mobilizations
15 Motion control
16 Muscle stimulation
17 Myofascial release
18 Occupational rehabilitation
19 Oxygen
20 Physiotherapy
21 Proprioception exercises
22 Range of motion exercises
23 Rest
24 SMT / adjustment
25 Soft tissue techniques
26 Steroid injections
27 Strengthening exercises
28 Stretching exercises
29 Suturing
30 TENS
31 Traction (manual)
32 Traction (mechanical)
33 Ultrasound
94 Other*

* *Provide details in the Additional Comments box*

Investigations

1 Blood tests / U/A
2 Bone scan
3 CT scan
4 EMS / NCS
5 Ultrasound
6 X-ray
95 Other*

Assistive Devices

1 Ankle brace
2 Arch supports
3 Back brace
4 Back support
5 Bandage
6 Cane
7 Cast
8 Cervical collar
9 Cervical pillow
10 Cold pack
11 Corset
12 Crutches
13 Dressing
14 Heating pad
15 Orthotics
16 Prosthesis
17 Sling
18 Splint
19 Strap, band
20 Walker
21 Walking boot
22 Wheelchair
96 Other*

* *Provide details in the Additional Comments box*

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Physician's Report

Dec, 2017

MD

SECTION A - GENERAL INFORMATION (please print clearly)

Claim #

1	Worker's last name	First name	Initial	Physician's last name	First name	
2	Mailing address Province Postal code	Contact telephone Date of birth yyyy/mm/dd		Mailing address Province Postal code		WorkplaceNL billing # Reporting fee requested? ☐ Yes ☐ No
3	MCP	Gender ☐ M ☐ F		Telephone	Fax	MCP fee codes
4	Occupation	Employer		Date / time of visit yyyy/mm/dd hh:mm ☐ AM ☐ PM		
5	Date of injury / incident yyyy/mm/dd	Did this injury develop over time without a specific injury / incident? ☐ Yes ☐ No		Are you the primary health care provider? ☐ Yes ☐ No	Where did you see the worker? ☐ Office ☐ Emergency	
				Is this an initial report of injury / incident? ☐ Yes ☐ No		

SECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED

6 Mechanism of injury / incident:

7 Use codes from code sheet
use more than one code where necessary

Part of Body	Code		Examination: Subjective Reports 1 2 3 4	Examination: Objective Findings 1 2 3 4	Examination: Diagnoses 1 2 3	Treatment plan: Treatments 1 2	Treatment plan: Investigations 1 2	Treatment plan: Assist. Devices 1 2
i.		☐ Left ☐ Right ☐ Centre						
Other:	Update Status							
ii.		☐ Left ☐ Right ☐ Centre						
Other:	Update Status							
iii.		☐ Left ☐ Right ☐ Centre						
Other:	Update Status							

Did this injury aggravate a prior health issue? ☐ Yes ☐ No ☐ Don't know

Are there other issues affecting the worker's injury, recovery and / or disability? ☐ Yes ☐ No ☐ Don't know

If yes to either of the above please specify in Box 8.

8 Additional Comments - *or* - If you use any of the "other" codes above (except Part of Body), indicate the code # and provide details.

SECTION C - SPECIFIC INFORMATION FOR ALL DIAGNOSES (PERTAINING TO SECTION B)

9 Do you suggest WorkplaceNL arrange any specialty appointments? ☐ Yes ☐ No
If yes, please indicate: ☐ Interdisciplinary program ☐ EMG/NCS ☐ Neurosurgeon ☐ Orthopaedic surgeon
A referral letter must be attached.

10 Have you referred the worker to a specialist other than the request in Question 9? ☐ Yes ☐ No
If yes, Name _____
Specialty _____
Date of appointment (if known) yyyy/mm/dd

11 Have you prescribed opioids during this visit? ☐ Yes ☐ No

12 Did you add, discontinue or change medications during this visit?
☐ Yes - *Complete table at right*
☐ No - *Go to Section D*

	Drug name	Status	Dose	Frequency	Quantity	Repeat
1.		☐ Add ☐ Discontinue ☐ Change				
2.		☐ Add ☐ Discontinue ☐ Change				
3.		☐ Add ☐ Discontinue ☐ Change				

SECTION D - RETURN-TO-WORK STATUS

13 Explanation of current functional abilities *check all that apply and specify details in the space provided*

- ☐ Worker has full functional abilities to return to work **(please go to Section E)**
- ☐ Lifting restrictions, specify ◯ < 10 lbs ◯ < 20 lbs ◯ < 50 lbs ◯ Avoid repetitive lifting ◯ No lifting
- ☐ Bending / twisting restrictions, specify ◯ No bending / twisting ◯ Avoid repetitive bending / twisting
- ☐ Standing restrictions, specify _____
- ☐ Climbing (stairs / ladders) restrictions, specify _____
- ☐ Kneeling / crouching restrictions, specify _____
- ☐ Sitting restrictions, specify _____
- ☐ Walking restrictions, specify _____
- ☐ Upper extremity restrictions, specify _____
- ☐ Restrictions due to medications, specify _____
- ☐ Limitations due to environment, specify _____
- ☐ Other limitations, specify _____

14 What are the recommended work hours? ☐ Pre-injury / incident ☐ Other: _____ Should the hours be graduated? ☐ Yes ☐ No

15 Estimate duration of current functional abilities: ☐ 1 to 2 days ☐ 3 to 7 days ☐ 8 to 14 days ☐ 15+ days

SECTION E - FOLLOW-UP

16 Have you reviewed the details of this report with the worker? ☐ Yes ☐ No
Have you provided a copy of this report to the worker? ☐ Yes ☐ No
Have you provided a copy of this report to the worker to give to the employer? ☐ Yes ☐ No

17 Is a follow-up appointment required? ☐ Yes ☐ No
If yes, when should the appointment occur? ☐ 1 to 7 days ☐ 8 to 14 days ☐ 15 to 21 days ☐ 22+ days
Do you want WorkplaceNL to call you? ☐ Yes ☐ No

18 I certify this is a complete and accurate report and I have received no prior payment from WorkplaceNL for this visit.
Date yyyy/mm/dd

Signature _____

WHITE – PHYSICIAN'S COPY **YELLOW** – EMPLOYER'S COPY (WORKER TO DELIVER AND DISCUSS WITH EMPLOYER) **BLUE** – WORKER'S COPY

Dec. 2017

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Physician's Report

MD

SECTION A - GENERAL INFORMATION (please print clearly)

Claim #

1	Worker's last name	First name	Initial	Physician's last name	First name
2	Mailing address Province Postal code	Contact telephone Date of birth yyyy/mm/dd		Mailing address Province Postal code	
3		Gender ☐ M ☐ F		Telephone	Fax
4	Occupation	Employer		Date / time of visit yyyy/mm/dd hh:mm ☐ AM ☐ PM	
5	Date of injury / incident yyyy/mm/dd	Did this injury develop over time without a specific injury / incident? ☐ Yes ☐ No			

SECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED

7	Use codes from code sheet *use more than one code where necessary*		
	Part of Body	Code	
i.		☐ Left ☐ Right ☐ Centre	
Other:			Update Status
ii.		☐ Left ☐ Right ☐ Centre	
Other:			Update Status
iii.		☐ Left ☐ Right ☐ Centre	
Other:			Update Status

Code details provided on reverse.

SECTION D - RETURN-TO-WORK STATUS

13 Explanation of current functional abilities *check all that apply and specify details in the space provided*

- ☐ Worker has full functional abilities to return to work **(please go to Section E)**
- ☐ Lifting restrictions, specify ◯ < 10 lbs ◯ < 20 lbs ◯ < 50 lbs ◯ Avoid repetitive lifting ◯ No lifting
- ☐ Bending / twisting restrictions, specify ◯ No bending / twisting ◯ Avoid repetitive bending / twisting
- ☐ Standing restrictions, specify _____ ☐ Climbing (stairs / ladders) restrictions, specify _____
- ☐ Kneeling / crouching restrictions, specify _____ ☐ Sitting restrictions, specify _____
- ☐ Walking restrictions, specify _____ ☐ Upper extremity restrictions, specify _____
- ☐ Restrictions due to medications, specify _____ ☐ Limitations due to environment, specify _____
- ☐ Other limitations, specify _____

14 What are the recommended work hours? ☐ Pre-injury / incident ☐ Other: _____ Should the hours be graduated? ☐ Yes ☐ No

15 Estimate duration of current functional abilities: ☐ 1 to 2 days ☐ 3 to 7 days ☐ 8 to 14 days ☐ 15+ days

SECTION E - FOLLOW-UP

16	Have you reviewed the details of this report with the worker? ☐ Yes ☐ No	Have you provided a copy of this report to the worker? ☐ Yes ☐ No	Have you provided a copy of this report to the worker to give to the employer? ☐ Yes ☐ No
17	Is a follow-up appointment required? ☐ Yes ☐ No	If yes, when should the appointment occur? ☐ 1 to 7 days ☐ 8 to 14 days ☐ 15 to 21 days ☐ 22+ days	

18 I certify this is a complete and accurate report and I have received no prior payment from WorkplaceNL for this visit.

Signature _____ Date yyyy/mm/dd

WHITE – PHYSICIAN'S COPY **YELLOW** – EMPLOYER'S COPY (WORKER TO DELIVER AND DISCUSS WITH EMPLOYER) **BLUE** – WORKER'S COPY

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Supporting Information

Employers and workers are obligated under the *Workplace Health, Safety and Compensation Act* to co-operate in the worker's early and safe return to suitable and available employment with the injury employer. This may involve modified work, ease back to regular work, transfer to an alternate job, or trial work to assess the worker's capability.

The worker is responsible for providing the employer's copy of the form MD, physician's report, to the employer by the next working day following the physician's visit. If a worker cannot provide the form in person he/she must contact the employer and provide the information by telephone, e-mail or fax.

Worker co-operation:

(i) contact the injury employer as soon as possible after the injury occurs and maintain effective communication throughout the period of recovery or impairment;
(ii) assist the employer, as may be required or requested, to identify suitable and available employment;
(iii) accept suitable employment when identified; and
(iv) give WorkplaceNL any information requested concerning the return-to-work plan, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

Employer co-operation:

(i) contact the worker as soon as possible after the injury occurs and maintain effective communication throughout the period of the worker's recovery or impairment;
(ii) provide suitable and available employment. The employer is responsible to pay the worker's salary earned during the early and safe return-to-work plan. WorkplaceNL will pay the differential, if any, between the salary earned during the early and safe return-to-work plan and 85% of the worker's net pre-injury earnings subject to the maximum compensable ceiling; and
(iii) give WorkplaceNL any information requested concerning the worker's return to work, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

Part of Body

1 Abdomen	11 Face	21 Lower leg	31 Thoracolumbar region
2 Ankle	12 Finger	22 Lumbar region	32 Toe
3 Arm	13 Foot	23 Lumbosacral region	33 Wrist
4 Brain	14 Forearm	24 Lung, airways	90 Other
5 Cervical region	15 Groin	25 Pelvis	
6 Chest	16 Hand	26 Ribs	
7 Coccyx	17 Head	27 Sacroiliac region	
8 Ear	18 Heel	28 Shoulder	
9 Elbow	19 Hip	29 Thigh	
10 Eye	20 Knee	30 Thoracic region	

Dec. 2017

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Physician's Report

MD

SECTION A - GENERAL INFORMATION (please print clearly)

Claim #

1	Worker's last name	First name	Initial	Physician's last name	First name
2	Mailing address Province Postal code	Contact telephone Date of birth yyyy/mm/dd		Mailing address Province Postal code	**CODES FOR SECTION B ON REVERSE**
3	MCP	Gender ☐ M ☐ F		Telephone	Fax
4	Occupation	Employer		Date / time of visit yyyy/mm/dd hh:mm ☐ AM ☐ PM	
5	Date of injury / incident yyyy/mm/dd	Did this injury develop over time without a specific injury / incident? ☐ Yes ☐ No		Are you the primary health care provider? ☐ Yes ☐ No	Where did you see the worker? ☐ Office ☐ Emergency
				Is this an initial report of injury / incident? ☐ Yes ☐ No	

SECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED

6 Mechanism of injury / incident:

7 Use codes from code sheet
use more than one code where necessary

Part of Body Code		Examination: Subjective Reports 1 2 3 4	Examination: Objective Findings 1 2 3 4	Examination: Diagnoses 1 2 3	Treatment plan: Treatments 1 2	Treatment plan: Investigations 1 2	Treatment plan: Assist. Devices 1 2
i.	☐ Left ☐ Right ☐ Centre						
Other:	Update Status						
ii.	☐ Left ☐ Right ☐ Centre						
Other:	Update Status						
iii.	☐ Left ☐ Right ☐ Centre						
Other:	Update Status						

Did this injury aggravate a prior health issue? ☐ Yes ☐ No ☐ Don't know

Are there other issues affecting the worker's injury, recovery and / or disability? ☐ Yes ☐ No ☐ Don't know

If yes to either of the above please specify in Box 8.

8 Additional Comments - *or* - If you use any of the "other" codes above (except Part of Body), indicate the code # and provide details.

SECTION C - SPECIFIC INFORMATION FOR ALL DIAGNOSES (PERTAINING TO SECTION B)

9 Do you suggest WorkplaceNL arrange any specialty appointments? ☐ Yes ☐ No
If yes, please indicate: ☐ Interdisciplinary program ☐ EMG/NCS ☐ Neurosurgeon ☐ Orthopaedic surgeon
A referral letter must be attached.

10 Have you referred the worker to a specialist other than the request in Question 9? ☐ Yes ☐ No
If yes, Name _____ Specialty _____
Date of appointment (if known) yyyy/mm/dd

11 Have you prescribed opioids during this visit? ☐ Yes ☐ No

12 Did you add, discontinue or change medications during this visit?
☐ Yes - *Complete table at right*
☐ No - *Go to Section D*

	Drug name	Status	Dose	Frequency	Quantity	Repeat
1.		☐ Add ☐ Discontinue ☐ Change				
2.		☐ Add ☐ Discontinue ☐ Change				
3.		☐ Add ☐ Discontinue ☐ Change				

SECTION D - RETURN-TO-WORK STATUS

13 Explanation of current functional abilities *check all that apply and specify details in the space provided*

- ☐ Worker has full functional abilities to return to work **(please go to Section E)**
- ☐ Lifting restrictions, specify ◯ < 10 lbs ◯ < 20 lbs ◯ < 50 lbs ◯ Avoid repetitive lifting ◯ No lifting
- ☐ Bending / twisting restrictions, specify ◯ No bending / twisting ◯ Avoid repetitive bending / twisting
- ☐ Standing restrictions, specify _____ ☐ Climbing (stairs / ladders) restrictions, specify _____
- ☐ Kneeling / crouching restrictions, specify _____ ☐ Sitting restrictions, specify _____
- ☐ Walking restrictions, specify _____ ☐ Upper extremity restrictions, specify _____
- ☐ Restrictions due to medications, specify _____ ☐ Limitations due to environment, specify _____
- ☐ Other limitations, specify _____

14 What are the recommended work hours? ☐ Pre-injury / incident ☐ Other: _____ Should the hours be graduated? ☐ Yes ☐ No

15 Estimate duration of current functional abilities: ☐ 1 to 2 days ☐ 3 to 7 days ☐ 8 to 14 days ☐ 15+ days

SECTION E - FOLLOW-UP

16	Have you reviewed the details of this report with the worker? ☐ Yes ☐ No	Have you provided a copy of this report to the worker? ☐ Yes ☐ No	Have you provided a copy of this report to the worker to give to the employer? ☐ Yes ☐ No
17	Is a follow-up appointment required? ☐ Yes ☐ No	If yes, when should the appointment occur? ☐ 1 to 7 days ☐ 8 to 14 days ☐ 15 to 21 days ☐ 22+ days	Do you want WorkplaceNL to call you? ☐ Yes ☐ No

18 I certify this is a complete and accurate report and I have received no prior payment from WorkplaceNL for this visit.

Signature _____ Date yyyy/mm/dd

WHITE – PHYSICIAN'S COPY **YELLOW** – EMPLOYER'S COPY (WORKER TO DELIVER AND DISCUSS WITH EMPLOYER) **BLUE** – WORKER'S COPY

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The worker is responsible for providing the employer's copy of the form MD, physician's report, to the employer by the next working day following the physician's visit. If a worker cannot provide the form in person he/she must contact the employer and provide the information by telephone, email or fax.

Worker co-operation:

(i) contact the injury employer as soon as possible after the injury occurs and maintain effective communication throughout the period of recovery or impairment;
(ii) assist the employer, as may be required or requested, to identify suitable and available employment;
(iii) accept suitable employment when identified; and
(iv) give WorkplaceNL any information requested concerning the return-to-work plan, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

Employer co-operation:

(i) contact the worker as soon as possible after the injury occurs and maintain effective communication throughout the period of the worker's recovery or impairment;
(ii) provide suitable and available employment. The employer is responsible to pay the worker's salary earned during the early and safe return-to-work plan. WorkplaceNL will pay the differential, if any, between the salary earned during the early and safe return-to-work plan and 85% of the worker's net pre-injury earnings subject to the maximum compensable ceiling; and
(iii) give WorkplaceNL any information requested concerning the worker's return to work, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

Part of Body

1 Abdomen
2 Ankle
3 Arm
4 Brain
5 Cervical region
6 Chest
7 Coccyx
8 Ear
9 Elbow
10 Eye
11 Face
12 Finger
13 Foot
14 Forearm
15 Groin
16 Hand
17 Head
18 Heel
19 Hip
20 Knee
21 Lower leg
22 Lumbar region
23 Lumbosacral region
24 Lung, airways
25 Pelvis
26 Ribs
27 Sacroiliac region
28 Shoulder
29 Thigh
30 Thoracic region
31 Thoracolumbar region
32 Toe
33 Wrist
90 Other

Subjective Reports

1 Burning
2 Difficulty sitting
3 Difficulty standing
4 Difficulty walking
5 Dizziness
6 Headache
7 Interrupted sleep
8 Numbness
9 Limited weight bearing
10 Pain (mild)
11 Pain (moderate)
12 Pain (severe)
13 Pain radiating
14 Stiffness
15 Tenderness
16 Tingling
17 Weakness
88 No subjective reports
91 Other

Objective Findings

1 Abnormal gait
2 Abnormal reflexes
3 Abnormal sensation (dermatomal)
4 Abnormal sensation (non-dermatomal)
5 Atrophy
6 Bleeding
7 Bruising
8 Crepitus
9 Decreased air entry
10 Decreased range of motion
11 Deformity
12 Hypermobility
13 Hypertonicity
14 Hypomobility
15 Hypotonicity
16 Infection
17 Joint effusion
18 Laceration
19 Leg length discrepancy
20 Level of conditioning (good)
21 Level of conditioning (fair)
22 Level of conditioning (poor)
23 Range of motion (100%)
24 Range of motion (≥75%)
25 Range of motion (≥50%)
26 Range of motion (≥25%)
27 Range of motion (<25%)
28 Rash
29 Redness / discoloration

(Physician use only - provide details in box 8)

Physiotherapy and Chiropractic use only

30 Scar
31 Sensory loss
32 Spasm
33 Straight leg raise (Negative)
34 Straight leg raise (60+)
35 Straight leg raise (30-60)
36 Straight leg raise (0-30)
37 Strength (5/5)
38 Strength (4/5)
39 Strength (3/5)
40 Strength (2/5)
41 Strength (1/5)
42 Swelling
43 Upper limb neural tension test (+ve)
44 Upper limb neural tension test (-ve)
45 Wasting
46 Weakness
47 Wheezing
89 No objective findings
92 Other

Update status to be added for follow up on Subjective Reports and Objective Findings.

A Resolution
B Significant improvement
C Moderate improvement
D Mild improvement
E No change
F Worsening

Diagnosis

1 Abrasion
2 Allergic reaction
3 Amputation
4 Asthma
5 Burn
6 Bursitis
7 Carpal tunnel syndrome
8 Chronic obstructive pulmonary disease
9 Contusion
10 Crush
11 Dermatitis
12 Disc injury
13 Dislocation
14 Epicondylitis
15 Fracture
16 Frozen shoulder
17 Hernia
18 Herniated disc
19 Infection
20 Inflammation
21 Laceration
22 Ligament sprain (1st)
23 Ligament sprain (2nd)
24 Ligament tear (3rd degree sprain)
25 Mechanical back pain
26 Meniscal tear
27 Muscle strain
28 Plantar fasciitis
29 Puncture
30 Radiculopathy
31 Repetitive strain
32 Rotator cuff impingement
33 Rotator cuff injury
34 Rotator cuff tear
35 Spinal cord injury
36 Spinal stenosis
37 Spondylolisthesis
38 Tendonitis
39 Tenosynovitis
40 Traumatic spondylolisthesis / lysis
93 Other

Treatments

1 Acupuncture
2 Casting
3 Chiropractic
4 Cold
5 Conditioning exercises
6 Core stability exercises
7 Education
8 Heat
9 Home exercises
10 IFC
11 Laser
12 Manipulations
13 Massage
14 Mobilizations
15 Motion control
16 Muscle stimulation
17 Myofascial release
18 Occupational rehabilitation
19 Oxygen
20 Physiotherapy
21 Proprioception exercises
22 Range of motion exercises
23 Rest
24 SMT / adjustment
25 Soft tissue techniques
26 Steroid injections
27 Strengthening exercises
28 Stretching exercises
29 Suturing
30 TENS
31 Traction (manual)
32 Traction (mechanical)
33 Ultrasound
94 Other

Investigations

1 Blood tests / U/A
2 Bone scan
3 CT scan
4 EMS / NCS
5 Ultrasound
6 X-ray
95 Other

Assistive Devices

1 Ankle brace
2 Arch supports
3 Back brace
4 Back support
5 Bandage
6 Cane
7 Cast
8 Cervical collar
9 Cervical pillow
10 Cold pack
11 Corset
12 Crutches
13 Dressing
14 Heating pad
15 Orthotics
16 Prosthesis
17 Sling
18 Splint
19 Strap, band
20 Walker
21 Walking boot
22 Wheelchair
96 Other