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: workplacenl.ca 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																				
SEC	ECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED																				
6	Mechanism of injury / incident:																				
	Same as previously reported on the initial report.																				
7			om code sheet e code where necessary					Exan	ninati	ion							Treatn	nent pl	an		Did this injury aggravate a
Part of Body			Su	bjective Reports  Objective Findings		Diagnoses		Treatments Investigations		Assist, Devices		prior health issue?									
i.	22	Left [	Right Centre	11				1	10	92		27			20						Yes V No
Oth	ier:		Update Status	C				C	C												Are there other
ii.	90	Left [	Right Centre					29				1									issues affecting
Oth	er: No	se	Update Status					A													the worker's injury, recovery and / or
iii. Left Right Centre																				disability? ☐ Yes <b>▼</b> No	
Other: Update Status																				Don't know	
8	Additional Comments - or - If you use any of the "other" codes above (except Part of Body), indicate the code # and provide details.  If yes to either of the above please specify in Box 8.																				
	92 - negative bowstring test Decreased ROM - F.F. 40°, Ext. 10°C+RRotation NC+R Flexion N																				

### 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.

# workplacent.ca MD, 8/10c and PR Code Sheet

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WorkplaceNL

Effective Date: December 2017

Blood tests / U/A Assistive Devices \* Provide details in Cervical pillow Arch supports Cervical collar Investigations Back support Walking boot Heating pad CT scan EMS / NCS Comments box Ankle brace Back brace Strap, band Wheelchair Ultrasound Bone scan **Prosthesis** the Additional Cold pack Bandage Crutches Dressing Orthotics Walker Corset Other\* X-ray Other\* Cane Cast 95 8 19 Occupational rehabilitation Range of motion exercises Proprioception exercises Strengthening exercises Conditioning exercises Core stability exercises Soft tissue techniques Additional Comments box Traction (mechanical) Stretching exercises Myofascial release Muscle stimulation \* Provide details in the SMT / adjustment Steroid injections Fraction (manual) Home exercises **Physiotherapy Manipulations** Motion control Mobilizations Acupuncture Chiropractic Ultrasound Education Massage **Treatments** Suturing Oxygen Casting Laser 33 33 34 2 9 18 19 25 26 27 28 28 29 30 Chronic obstructive pulmonary disease Traumatic spondylolisthesis / lysis Ligament tear (3rd degree sprain) Rotator cuff impingement Carpal tunnel syndrome Additional Comments box Ligament sprain (2nd) Ligament sprain (1st) Mechanical back pain Provide details in the Rotator cuff injury Spondylolisthesis Spinal cord injury Repetitive strain Rotator cuff tear Allergic reaction Frozen shoulder Plantar fasciitis Spinal stenosis Herniated disc Radiculopathy **Tenosynovitis** nflammation Meniscal tear Muscle strain Epicondylitis Amputation Dislocation Laceration Disc injury Contusion **Dermatitis Fendonitis** Puncture Fracture Infection Abrasion Diagnosis Asthma Hernia Bursitis Crush Burn 39 10 12 13 4 15 16 17 Upper limb neural tension test (-ve) Provide details in the Additional Decreased range of motion (Physician use only) (Provide details in box 8) No objective findings Update status to be added for follow up on Subjective Reports and Objective Findings. Comments box 46 Weakness Wheezing Wasting Mild improvement 89 Physiotherapy and Chiropractic use only 4 **Objective Findings** No change Worsening Abnormal sensation (non-dermatomal) Ошц Upper limb neural tension test (+ve) Abnormal sensation (dermatomal) -evel of conditioning (good) Straight leg raise (Negative) evel of conditioning (poor) Level of conditioning (fair) Straight leg raise (30-60) Range of motion (100%) Range of motion (≥75%) Range of motion (≥50%) Range of motion (≥25%) Range of motion (<25%) Straight leg raise (0-30) Leg length discrepancy Redness / discoloration Straight leg raise (60+) Significant improvement Decreased air entry Moderate improvement Abnormal reflexes Strength (5/5) Abnormal gait Strength (4/5) Strength (3/5) Strength (2/5) Strength (1/5) Hypermobility Joint effusion Sensory loss Hypertonicity Hypomobility **Hypotonicity** Laceration Deformity Bleeding Crepitus Atrophy Bruising Resolution Spasm  $\forall$   $\square$   $\square$ Additional Comments box \_imited weight bearing No subjective reports Provide details in the Subjective Reports Difficulty standing Interrupted sleep Difficulty walking Pain (moderate) Difficulty sitting Pain radiating Pain (severe) **Tenderness** Numbness Headache Pain (mild) Weakness Dizziness Stiffness Fingling 88 Thoracolumbar region Lumbosacral region \* Provide details in the Sacroiliac region Other box located under Part of Body Thoracic region Cervical region Lumbar region -ung, airways Part of Body Lower leg Abdomen Shoulder -orearm Coccyx Finger Chest Elbow Pelvis Thigh Ankle Brain Groin Face Hand Head Knee Wrist Foot Heel <u>S</u> 20 22 23 23 24 25 26 26 27 28 29 30 31

WorkplaceNL

Signature\_

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Dec, 2017

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SEC	TION A - GENERAL INFORM	IATION (p	olease pri	int clearly)		Claim #							•	
1	Worker's last name	ı	First name		Initial	Physician	's last r	name			First nar	ne		
2	Mailing address		Conta	ct telephone	phone 1		ddress				WorkplaceNL billing #		ling #	
H	Province					Province								
	Postal code		Date	Date of birth yyyy/mm/dd		Postal code		1				Reporting	fee red	quested? ] No
	MCD								Fax				fee co	
3	MCP		Gende	er M	F	Telephone			гах					
4	Occupation	En	nployer			Date / time	e of vis	sit yyyy/mm/o	dd h ∎	h:mm I	AM		_	
							Щ.	<del></del>			PM			
5	Date of injury / incident	Did this iniu	ıry develop			Are you the health car			Yes No		re did you he worker	$\sim =$	Office Emerg	encv
Г	vvvv/mm/dd c	over time w		i res		Is this an i	initial re	eport of inju		 ident?	☐ Yes ☐ No			
			-											
	TION B - SPECIFIC INFORMAT	TION FOR	PARTS O	F BODY INJ	URED									
6	Mechanism of injury / incident:													
	Use codes from code sheet											1		
7	use more than one code where necessary			Examination	ı				Treatm	ent plan	l	aggra	his injւ avate ն	a
	Part of Body	Subjectiv	ve Reports	Objective Fi	ndings 3 4	Diagnose:	s T	Treatments Investigations A			ssist. Devic		prior health issue?	
i.	Left Right Centre						$\perp$					Yes No		_
Othe	r: Update Status											<u> </u>	here o	
ii.	Left Right Centre											issue	es affe	
Othe	Update Status											reco	very ar	
iii.	Left Right Centre												oility? ′es	No
Othe	Update Status											_  🗖 🛭	on't k	now
8	Additional Comments - or - If you	u use any o	f the "other"	codes above (	except P	art of Body),	indicate	e the code #	and pro	ovide deta	ails.		o either of specify in	f the above n Box 8.
SEC	TION C - SPECIFIC INFORM	ATION FO	DR ALL D	IAGNOSES	(PERT	AINING TO	SEC.	TION B)						
9	Do you suggest WorkplaceNL	☐ Ye	s If v	es, please [	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	disciplinary p	prograr	m ∏ Ne	urosurg	eon		A refe	rral le	tter
	arrange any specialty appointmen			icate:		NCS				ic surged	on	must l	be atta	ched.
10	Have you referred the worker to	a specialis	st	If yes, Na	ame						Date of	appointm		known)
	other than the request in Question	on 9?	☐ No									<u> </u>		
11	Have you prescribed opioids dur	ring this vis	sit? \ \ Ye	es 🗆 No										
12	Did you add discontinus or show			Drug nome			C+	totus		Dose	Freque	ancy Out	antity	Repeat
<u></u>	Did you add, discontinue or char medications during this visit?	nge 1.	Drug name			Status Dos			Dose	Frequency Qu		aritity	Nepeat	
	Yes - Complete table at right	2.				Add	=-		Change					
	☐ No - Go to Section D	3.				Add [	Disc	continue	Change					
SEC	TION D - RETURN-TO-WORK		 S											
13	Explanation of current functional			ply and specify det	ails in the s	pace provided								
Г	☐ Worker has full functional a													
	Lifting restrictions, specify	< 10 <b>&lt;</b> 10	lbs	0 lbs () < 50	lbs $\bigcirc$ A	void repetiti	ive liftir	ng O No	lifting					
	■ Bending / twisting restriction	ons, specify	/ O No b	ending / twisti	ng 🔘	Avoid repet	itive be	ending / twi	sting					
	☐ Standing restrictions, spec	ify			[	Climbing	ı (stairs	/ ladders)	restriction	ons, spe	cify			
		ctions, spe	cify		[	Sitting re	estrictio	ns, specify						
					_		-		-	-				
	Restrictions due to medica		•					to environi	ment, sp	ecify				
	Other limitations, specify _											_		
14	What are the recommended wor	k hours?	Pre-in	jury / incident	Ot	her:		Should the	hours b	e gradua	ated?	Yes [	No	
15	Estimate duration of current fund	ctional abili	ties: 🔲 1	to 2 days	] 3 to 7	days 🗌 8	8 to 14	days 🗌	15+ day	/s				
SEC	TION E - FOLLOW-UP													
16	Have you reviewed the details of this report with the worker?	Yes No		ou provided a co		Yes No		ve you prov he worker				Yes No		
17	Is a follow-up Yes appointment required?		s, when sho ppointmen	ould	1 to 7 d	_	15 to 2	1 days	Do you	want		Yes		
18	I certify this is a complete and ac				8 to 14 no prior p		22+ da n Work				all you?	No Date		
	•											yyyy/mm/d	u	

								Dec. 2017
We	SikplaceiiL	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: workplacenl	.ca	Physician's Report		MD
SEC	TION A - GENERAL INF	ORMATION (	please print clearl	y)	Claim #	-		
1	Worker's last name		First name	Initial	Physician's la	I I I I I I A	First name	
2	Mailing address		Contact telepho	ne	Mailing addre	ess		
			Date of birth yyy	n/mm/dd				
	Postal code		Date of birtin yyy	,   , ,	Postal code			
3			Gender □ M	<u></u>	Telephone	Fax		
4	Occupation	F	mployer	Ш'	Date / time o	f visit yyyy/mm/dd hh:mm		
-	Occupation	-	прюует		Date / time o	VISIT 77777777777	∐ AM I □ PM	
L								
5	Date of injury / incident		jury develop	⁄es				
	yyyy/mm/dd	over time v specific inj	without a 🗀	No				
SECT	ION B - SPECIFIC INFO	RMATION FOR	PARTS OF BODY	INJURED				
OLO!	ION B - OF LOW IO IN OF	CIMATION 1 OI	CTARTO OF BODT	INOUNED				
7	Use codes from code shee	et						
Ľ	use more than one code where need	cessary						
	Part of Body							
i.	<u> </u>	Centre						
Other	Update Sta		Code	details p	orovided o	n reverse.		
ii. Other	<u> </u>	Centre						
<u> </u>	Update Sta							
iii.	<u> </u>	Centre						
Otrioi	Update Sta	atus						
SEC <sup>-</sup>	FION D - RETURN-TO-V  Explanation of current funct  Worker has full funct  Lifting restrictions, sp	ctional abilities of	check all that apply and speci	e go to Sect	ion E)	lifting \( \cap \) No lifting		
	☐ Bending / twisting res	strictions, speci	fy O No bending / t	wisting $\bigcirc$	Avoid repetitive	e bending / twisting		
	☐ Standing restrictions	, specify			Climbing (st	airs / ladders) restrictions, s	pecify	
		restrictions, spe	ecify		Sitting restri	ictions, specify		
				_	_	mity restrictions, specify		
			-			due to environment, specify		
	Other limitations, spe							
14	What are the recommende	ed work hours?	Pre-injury / incid	lent  Ot	her:	_ Should the hours be grad	duated?	] No
15	Estimate duration of currer	nt functional abi	ilities: 1 to 2 days	3 to 7	days 🔲 8 to	14 days 15+ days		
SEC	ΓΙΟΝ E - FOLLOW-UP							
16	Have you reviewed the de of this report with the work		Have you provided of this report to the		Yes No	Have you provided a copy of to the worker to give to the		
17	Is a follow-up appointment required?		es, when should appointment occur?	☐ 1 to 7 d ☐ 8 to 14		to 21 days + days		
18	I certify this is a complete	and accurate re	port and I have receiv	ed no prior p	payment from V	VorkplaceNL for this visit.	Date yyyy/mm/o	bk
	Signature							



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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:

- 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
- 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:**

- 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.

art 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					

	nl oo	nysician's eport				MD
	Claim #					
Initial	Physician's la	st name		First name		
	Mailing addre	SS				
	Province					
n/dd I	Postal code	$\neg$			CODES   SECTION	
   <sub>F</sub>	Telephone	Fax			REVER	
	Date / time of	visit yyyy/mm/dd	hh:mm			
	L L L	i i i i i i i i i i i i i i i i i i i	1 .	AM   PM		
	Are you the p			ere did you	Office	
	health care p	rovider? No	see	the worker?	Emerg	jency
	Is this an initia	al report of injury / ind	cident?	Yes	] No	
URED						
1		Treatn	n	Did this inj aggravate		
ndings 3 4	Diagnoses	Treatments Investi	gations 2	Assist, Devices	prior healtl	
					Yes Don't k	☐ No
			$\longrightarrow$		Are there	
$\perp$			Щ		issues affe the worker	ecting
_			$\dashv$		recovery a disability?	
			$\sqcup$		Yes [	No
aveent I	Dowt of Rody () indi	cate the code # and pi	rovido do	toilo	Don't l	
Схооргі	art or Body), mar		ovide de		please specify i	
<u> </u>	AINING TO SE					
Inte	AINING TO SE		-		A referral le	
Inte	rdisciplinary prog G/NCS	gram Neurosurg	dic surge	eon		ached.
Inte	rdisciplinary prog G/NCS	gram Neurosurg	dic surge	Date of ap	must be att	ached.
Inte	rdisciplinary prog G/NCS	gram Neurosurg	dic surge	Date of ap	must be att	ached.
Inte	rdisciplinary prog G/NCS	gram Neurosurg	dic surge	Date of app	pointment (if	known)
Inte	rdisciplinary prog	gram Neurosurg Orthopaed	dic surge	Date of app	pointment (if	known)
Inte	G/NCS	gram Neurosurg	dic surge	Date of app	pointment (if	known)
Inte	Add Add	Status  Discontinue Change	dic surge	Date of app	pointment (if	known)
Inte	Add Add	Status  Discontinue Change	dic surge	Date of app	pointment (if	known)
Inter	Add Add Add Add Add	Status  Discontinue Change	dic surge	Date of app	pointment (if	known)
Inter	Add Add Space provided	Status  Discontinue Change	dic surge	Date of app	pointment (if	known)
Inter EMC	Add Add Space provided	Status  Discontinue Change	dic surge	Date of app	pointment (if	known)
Inter EMC	Add	Status  Discontinue Change  Discontinue Change  Change	dic surge	Date of app	pointment (if	known)
Intermediate in the cook of th	Avoid repetitive	Status  Discontinue Change  Discontinue Change  Discontinue Change	Dose	Date of app	pointment (if	Repeat

### **SECTION D - RETURN-TO-WORK STATUS**

WorkplaceNL

Worker's last name

Mailing address

Province

MCP

Occupation

Date of injury / incident

yyyy/mm/dd

Mechanism of injury / incident:

Use codes from code sheet use more than one code where necess

Left Right Centre

Left Right Centre

Left Right Centre

Do you suggest WorkplaceNL

arrange any specialty appointments? No

other than the request in Question 9?

Did you add, discontinue or change

at right No - Go to Section D

medications during this visit? Yes - Complete table

Have you referred the worker to a specialist

Have you prescribed opioids during this visit?

Update Status

**Update Status** 

Update Status

Part of Body

1

2

3

4

5

6

7

Other

ii.

Oth

iii.

Othe

8

10

11

12

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SECTION A - GENERAL INFORMATION (please print clearly)

CONTACT US AT:

First name

Gender

Employer

Did this injury develop over time without a

SECTION B - SPECIFIC INFORMATION FOR PARTS OF BODY INJURED

specific injury / incident?

Subjective Reports

Additional Comments - or - If you use any of the "other" codes above (except Par

SECTION C - SPECIFIC INFORMATION FOR ALL DIAGNOSES (PERTAI

2.

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Contact telephone

Date of birth yyyy/mm/dd

Yes

☐ No

**Examination** 

If yes, please indicate:

If yes, Name

Specialty

☐ No

Drug name

Yes

☐ No

Objective Findings

VISIT US AT

JLC	TION B - 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						
	☐ 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  15+ days  15+ days						

SEC	SECTION E - FOLLOW-UP									
16	Have you reviewed the details of this report with the worker?									
17		If yes, when should								
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									



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# **Supporting Information**

Wheelchair

Other

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, email or fax.

### Worker co-operation:

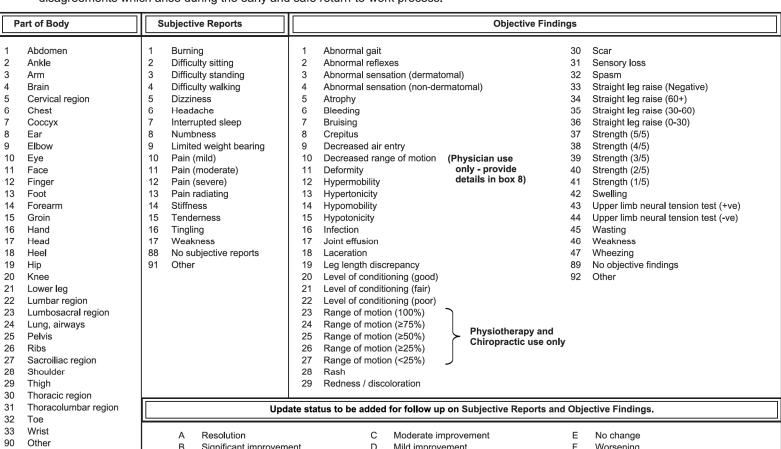
- contact the injury employer as soon as possible after the injury occurs and maintain effective communication throughout the period of recovery or impairment;
- assist the employer, as may be required or requested, to identify suitable and available employment;
- accept suitable employment when identified; and
- 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:**

35

Spinal cord injury

- 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;
- 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
- 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.



28 29 30	Shoulder Thigh Thoracic region	28 29	Rash Redness / discoloration								
31	Thoracolumbar region	Update status to be added for follow up on Subjective Reports and Objective Findings.									
32 33 90	Toe Wrist Other	A Resolution B Significant improvement	C Moderate imp D Mild improver								
Dia	agnosis			Treatments	Investigations						
1 2 3 4 5 6 7 8 9	Abrasion Allergic reaction Amputation Asthma Burn Bursitis Carpal tunnel syndrome Chronic obstructive pulmo	93 Other	nesis	1 Acupuncture 2 Casting 3 Chiropractic 4 Cold 5 Conditioning exercises 6 Core stability exercises 7 Education 8 Heat 9 Home exercises 10 IFC	1 Blood tests / U/A 2 Bone scan 3 CT scan 4 EMS / NCS 5 Ultrasound 6 X-ray 95 Other						
11	Dermatitis			11 Laser	Assistive Devices						
122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 30 311 32	Disc injury Dislocation Epicondylitis Fracture Frozen shoulder Hernia Herniated disc Infection Inflammation Laceration Ligament sprain (1st) Ligament sprain (2nd) Ligament tear (3rd degree Mechanical back pain Meniscal tear Muscle strain Plantar fasciitis Puncture Radiculopathy Repetitive strain Rotator cuff impingement	sprain)		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)	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						
32 33 34	Rotator cuff injury			32 Traction (mechanical) 33 Ultrasound 94 Other	20 Walker 21 Walking boot 22 Wheelchair						