WorkplaceNL

SEND BY FAX ONLY
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f 1.866.553.5119

CONTACT US AT:
t 709.778.1000
t 1.800.563.9000

VISIT US AT:
workplacenl.ca

Dentist's Report

DR

This report must be completed and faxed immediately to WorkplaceNL after examination. Billing accounts must be submitted on form 96.Important note regarding non-emergency dental treatment: before proceeding, the dentist must obtain prior approval from WorkplaceNL by submitting a written estimate of recommended dental work.

SECTION A - GENERAL INFORMATION

Claim #

1	Worker's last name	First name	Initial	Dentist'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 # Date of visit yyyy/mm/dd	
3	MCP	Gender ☐ M ☐ F		Telephone		
4	Occupation	Employer		Fax		

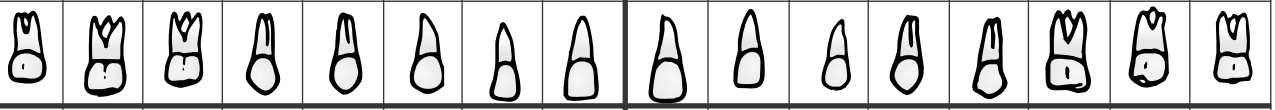
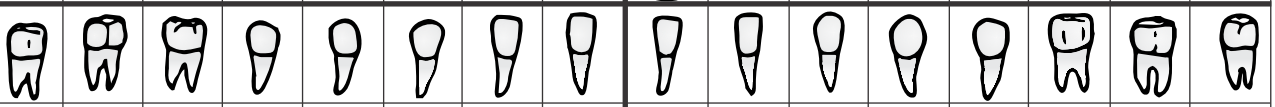
SECTION B - GENERAL INJURY INFORMATION

5	Is this an initial report of injury / incident? ☐ Yes ☐ No	Where did you see the worker? ☐ Office ☐ Emergency	
6	Date of injury / incident yyyy/mm/dd	Did this injury develop over time without a specific injury / incident? ☐ Yes ☐ No	
7	Description of mechanism of injury / incident:		

SECTION C - DENTAL SUMMARY

8 Mark this chart with a dental code and an injury code where applicable.

*For example: **FR1** - pre-injury fractured or broken tooth; **FR2** - fractured tooth as a result of the injury / incident, **FR3** - fractured tooth post-injury.*

	Right								Left							
	1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8
																
																
	4.8	4.7	4.6	4.5	4.4	4.3	4.2	4.1	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8

Dental codes

AV	Avulsion	**PE**	Pulpal exposure (class III dental fracture)	**RCT**	Root canal treated tooth	**R**	Rotated tooth	**EX**	Extrusion
M	Mobile	**X**	An extracted, missing, or lost tooth	**FR**	Fractured tooth	**LU**	Luxation	**IN**	Intrusion

Injury codes

1	Pre-injury	**2**	Injury / Incident	**3**	Post-injury

SECTION D - SPECIFIC INJURY / INCIDENT INFORMATION

9 Pertinent subjective reports:

☐ Pain ☐ Sensitivity (hot) ☐ No subjective findings

☐ Sensitivity (cold) ☐ Sensitivity (sweet) ☐ Other _____

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Worker's name	MCP

10 Pertinent objective findings: ☐ Swelling ☐ Bleeding ☐ Redness ☐ Tenderness ☐ Other: _____

11 Diagnosis: ☐ Fractured bone ☐ Traumatic laceration ☐ Gum/Injury ☐ Extrusion ☐ Luxation
☐ Fractured tooth ☐ Malocclusion ☐ Intrusion ☐ Avulsion ☐ Other: _____

12 Investigations: ☐ Plain x-ray ☐ Panorex ☐ Other: _____

13 Treatment plan:

Treatment required	Tooth number	Has treatment been completed?	If *yes*, provide details:	If *no*, provide expected date and estimate of cost	
				yyyy/mm/dd	cost
Extraction		☐ Yes ☐ No			
Filling		☐ Yes ☐ No			
Root canal		☐ Yes ☐ No			
Crown		☐ Yes ☐ No			
Bridge		☐ Yes ☐ No			
Denture		☐ Yes ☐ No			
Surgery		☐ Yes ☐ No			
Other		☐ Yes ☐ No			

14 Did this injury aggravate a prior health issue? ☐ Yes ☐ No ☐ Don't know
If yes, provide details:

15 Are there other issues affecting the worker's injury, recovery and / or disability? ☐ Yes ☐ No ☐ Don't know
If yes, provide details:

16 Are there future considerations affecting the worker's injury, recovery and / or disability? ☐ Yes ☐ No ☐ Don't know
If yes, provide details:

SECTION E - SPECIFIC INFORMATION FOR ALL DIAGNOSES

17 Consultation referrals:

Worker referred to specialist	Specialist code *choose code below*	Name of specialist	Appointment date (if known) yyyy/mm/dd
☐ Yes ☐ No			

Specialist type codes: 1. Endodontist 2. Orthodontist 3. Oral Surgeon 4. Periodontist 5. Prosthodontist

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

19 Did you add, discontinue or change medications during this visit?
☐ Yes - *complete table at right*
☐ No

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

20 Is follow-up required? ☐ Yes ☐ No | Scheduled follow-up yyyy/mm/dd | Do you want WorkplaceNL to call you? ☐ Yes ☐ No

21 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 _____