WCB, Halifax office
5668 South Street
PO Box 1150, Halifax NS, B3J 2Y2
Tel: 1-800-870-3331 toll free or 902-491-8999 local
Fax: 1-855-723-3975 or locally 902-491-8001

WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Referral Form for Centralized Surgical Services Program

CLIENT INFORMATION:

Last name: *Sample* | First Name: *Patient* | Initial: *B* | **WCB Claim #:** *01366423*

Address: *123 Main St., Apt. 218, Dartmouth* | Province: *NS* | Postal Code: *B2B 2B2*

Gender: [ ] M [X] F | Health Card #: *0000 000 000* | Family Physician Name: *DR. FAMILY PHYSICIAN*

Daytime Phone Number: *(902) 555-0248* | Evening Phone Number: *(902) 555-1729 cell* | Employer name: *ACME Inc.* | Date of Birth: *14* / *3* / *1982*

INJURY INFORMATION:

DATE OF INJURY: *23* / *4* / *2014* | **DIAGNOSIS:** *KNEE JOINT REPLACEMENT STATUS*

MECHANISM OF INJURY: (Details: action, activity, anatomic position, lifting, twisting, force direction and impact, torsion, etc.)

Aenean ut diam tellus. Suspendisse potenti. Aenean vitae justo eu elit cursus laoreet quis eget neque. Sed accumsan sem nunc, ut blandit ligula tempus id. Nullam dui velit, vehicula hendrerit ipsum sit amet, elementum fermentum nulla. Etiam nulla nisl, dapibus eu ultricies ac, gravida molestie velit. Integer leo nisl fauci.

ORTHO [ ] Right [ ] Left [ ] Bilateral

Upper: [ ] Shoulder [ ] Elbow [ ] Hand [ ] Wrist [ ] Carpal Tunnel

Lower: [ ] Hip [X] Knee [ ] Ankle [ ] Foot

General [ ] Inguinal Hernia [ ] Incisional Hernia [ ] Umbilical Hernia [ ] Other: _____

ENT [ ] Right [ ] Left [ ] Bilateral [ ] Nasal Fracture [ ] Post-Traumatic [ ] Nasal Occlusion [ ] Other

Spine [ ] Cervical [ ] Thoracic [ ] Lumber

Clinical Findings: [X] Decreased ROM [X] Swelling [ ] Weakness/power loss [ ] Neurological Abnormality [X] Gait Disturbance [ ] Abnormal SLR [ ] Abnormal/absent Reflexes [ ] Sensory Deficit [ ] Bowel/bladder [ ] Other: _____

Height: *183 cm* **Weight:** *83 kg* **Investigations** (include copy of report): [X] XRay [X] CT/MRI [ ] Nerve Conduction Studies [ ] Other

Details: *Aenean auctor facilisis luctus. Ut ornare vel elit at tempus. Quisque porttitor vestibulum massa, in auctor eros cursus at. Nam ac nibh vel elit placerat cursus vel et leo. Etiam interdum leo enimini.*

PAST MEDICAL HISTORY:

SURGICAL: *Cum sociis natoque penatibus et magnis dis parturient montes, nascetur ridiculus mus. Aliquam ut sapien quis nunc iaculis varius ac vel enim. Quisque euismod sit amet felis vel consectetur. Aenean varius purus vel lacus dignissim placerat. Fusce tristique hendrerit metus, vitae laoreet mi aliquetac.*

MEDICAL: [ ] Diabetes [ ] Heart Disease [X] Sleep Apnea [ ] COPD [ ] Psychiatric/Addictions [ ] Other: _____

ALLERGIES: *test, gluten, penicillin g (parenteral/aqueous)*

MEDICATIONS *Agenerase, Yasmin*

*attach list if necessary

Should the client be ineligible for CSSP, please check one:

[X] Return to the Referring Physician

[ ] Redirect the referral to the following Surgeon _____ and notify the Referring Physician

REFERRING PHYSICIAN CERTIFICATION:

Signature of Physician: _____ Phone Number: *(902) 555-5555*

Physician Name: *DR. REQUESTING PHYSICIAN* Date: *30* / *4* / *2014*

Address: *123 Any St., Suite 147 Halifax, NS B1B 1B1* WCB Physician # *15779*

*All additional pages and attachments to this Form must be annotated with the WCB Claim Number

Practimax Plus Facsimile