WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

Medical Report
Eye Injuries

PLEASE COMPLETE THIS FORM AND RETURN TO ADDRESS ON REVERSE

WCB Claim Number

Worker Information

Last Name		First Name				
Mailing Address (include postal code)	Community	Telephone (include area code)				
Residential Address	Date of Birth	YY	MM	DD	Sex ❑ M	❑ F
Employer's Name	Worker's Occupation					

Health Care Provider Information

Name of Health Care Provider								
Telephone (include area code)								
Address (include postal code)								
Date of Injury	YY	MM	DD	**Date of Exam**	YY	MM	DD	

WCB Supplier Billing Number

Fee Code _____ Fee Submitted _____
Fee Code _____ Fee Submitted _____
Report Form Fee _____ Fee Submitted _____
TOTAL $_____

1. Would you like a WCB Doctor to contact you? ❑ Yes ❑ No

2. Who rendered first treatment?

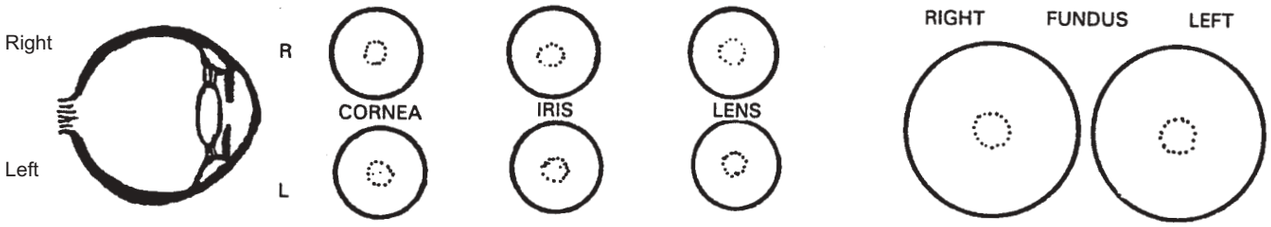
3. Date you first treated this patient YY MM DD

4. Which eye was injured? ❑ Right ❑ Left ❑ Both ICD Code:

5. Vision (at your first examination and before the treatment) Right Eye Left Eye

6. What did the worker say caused the injury?

7. Findings at the time of your examination (indicate on the diagram below, the location and extent of injury after fluorescein)



8. Treatment

9. Is there any evidence of previous disease or injury in either eye? ❑ Yes ❑ No If yes, give particulars

10. Do you expect any complications? ❑ Yes ❑ No If yes, please explain

11. Is permanent disability probable? ❑ Yes ❑ No

12. Current Work Disability Please estimate the period of disability - from date of exam
❑ No Disability ❑ 1-7 days ❑ 8-14 days ❑ 15-21 days ❑ More

13. Estimated return to work date YY MM DD

14. Is hospital care required? ❑ Yes ❑ No ❑ If yes, name of hospital

Health Care Provider's Signature _____ Date _____

I hereby certify that the above is a correct statement of services personally rendered by me.

NOTE TO SUPPLIERS:

We make payments on original invoices only. Faxed invoices or copies of invoices will not be paid.

RESPONSIBILITY OF HEALTH CARE PROVIDER

Excerpt from Section 17(3) of the Workers' Compensation Act

Report of Health Care Provider	17.(3)	A Health Care Provider who attends to a worker who has suffered a personal injury as the result of an accident arising out of and during the course of the worker's employment shall send the Board a report within three days after the date of his or her first attendance on the worker.

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Ce formulaire est disponible en français.
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