WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

Hand Arm Vibration (HAV) Syndrome Assessment Form

PLEASE COMPLETE THIS FORM AND RETURN TO ADDRESS LISTED BELOW

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				

PERIPHERAL VASCULAR ASSESSMENT

Symptoms? (vascular reactivity, timing, duration, anatomic sites)

Clinical Findings? (pulses, color, trophic changes, edema)

PERIPHERAL NEUROLOGICAL ASSESSMENT

Symptoms? (quality, timing, duration, anatomic distribution)

Clinical findings? (Sensory & Motor testing; Reflexes)

EXTREMITY MUSCULO-SKELETAL/ SKIN ASSESSMENT

Symptoms? (power, skin color, temperature)

Clinical findings? (ROM; atrophy; edema)

RELEVANT MEDICAL HISTORY

1) Concurrent disease(s) with vascular, neurological or musculo-skeletal sequelae?

2) Tobacco Use? Current or Past?

3) Current medication and/or herbal remedies?

4) Family history of Raynaud's Disorder?

5) Vibration exposures in non-occupational settings?

Health Care Provider's Signature ______________________ Date ______________

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

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax 1-866-277-3677

or

❑ Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8501

Ce formulaire est disponible en français.
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