Workers Compensation Board of Manitoba

Please FAX this form IMMEDIATELY
Winnipeg: 954-4999
Toll free: 1-877-872-3804
333 Broadway • Winnipeg R3C 4W3
Telephone 954-4922 • Toll free 1-800-362-3340

DOCTOR PROGRESS REPORT

Claim No. | 7

Worker Information

Last Name	First Name	Address		
City	Province	Postal Code	Date of Birth DD / MM / YYYY	PHIN ___-___-___

Injury Details

Date of Incident DD / MM / YYYY	Area of Injury

Examination Findings & Diagnosis

Date of Examination DD / MM / YYYY	ICD Code	Any changes in diagnosis? ☐ yes ☐ no	If yes, state new diagnosis

Subjective Complaints

Objective Findings (include ROM, muscle testing & neurological status)

Is recovery satisfactory? ☐ yes ☐ no If no, what are the complications/other factors impeding progress?

Tests performed or ordered (e.g. X-ray, CT Scan, MRI, etc.) Attach results	Location	Date DD / MM / YYYY DD / MM / YYYY

Referred to Consultant? ☐ yes ☐ no	If yes, name and address of Consultant	Date of Appointment DD / MM / YYYY

Treatment Plan

Description (e.g. physio, medication and dosages)	Date of Next Visit DD / MM / YYYY

Work Capabilities

When can Worker return to regular duties? Date DD / MM / YYYY ☐ Unknown at time of examination

Is Worker capable of alternate or modified work? ☐ yes ☐ no

If yes, outline restrictions

Duration of restrictions: _____ weeks

Physician Information

Physician Name	Telephone No. ( )	Fax No. ( )
Address	Physician Signature	Date DD / MM / YYYY
City / Province / Postal Code		

WCB 4035

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