PARKWAY
PHYSIOTHERAPY + PERFORMANCE CENTRE

WorkSafeBC Claims Information

Client Name (please print): _____

¨ Date of Injury: _____/_____/_____
(Day / Month / Year)

¨ WorkSafeBC Claim #: _____

¨ WorkSafeBC Case Manager: _____

¨ Case Manager's Phone: (_____)_____

¨ Employer's Name: _____

¨ Employer's Phone : (_____)_____

¨ Job Description/Duties: _____

¨ Have you submitted all paperwork to WorkSafeBC? ¨ Yes ¨ No

This section for office use only:

¨ Photocopied referral/referring doctor's name: _____

¨ PHN entered in CM

¨ Start:____/____/_____ ¨ End Date:____/_____/_____
(Initial tx Day / Month / Year) (Day / Month / Year)

¨ Stream 1 ¨ Stream 2
¨ Initial Notification faxed < 3 days ¨ Initial Notification faxed > 3 days
¨ Create WorkSafeBC dossier in CM with 22 Visits & 8 weeks end date

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This section for office use only:

¨ WorkSafeBC Approval
¨ ICD9 Diagnostic Code
¨ (NOI) Nature of Injury Code
¨ Body Part ¨ Second Body Part
¨ Side of Body ¨ Left ¨ Right ¨ Both ¨ N/A