Workers' Compensation Board
Alberta

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EDMONTON, AB T5J 2S5
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C1167

OCCUPATIONAL THERAPY SERVICES
Hand Therapy Initial Assessment

Please print clearly or type.

WCB Claim Number	Personal Health Number	Date of Accident *(yyyy/mm/dd)*

Worker's Surname	First Name	Initial	Date of Birth *(yyyy/mm/dd)*

Address Street	City/Town	Province	Postal Code	Telephone Number
				( )

Referral Source Name	Referral Source Contact Telephone Number	Date of Referral *(yyyy/mm/dd)*
	( )	
Provider Contact Name	**Provider Contact Telephone Number**	**Assessment Date *(yyyy/mm/dd)***
	( )	

GENERAL

Background

1. **Referral Questions:**
2. **Background:**
3. **Brief History:**
4. **Claimants Height (inches) weight (lbs)**

ASSESSMENT FINDINGS

1. **Subjective reports:**
2. **Objective findings:**
3. **Non-compensable factors (if applicable):**

TREATMENT GOALS

Goals and treatment plan	Methodology	Timeframe

OTHER

Can the worker perform modified or alternative duties? ☐ Yes ☐ No

If, yes – please specify work capability:

☐ Sedentary ☐ Light ☐ Medium ☐ Heavy

Are there any specific tasks that should be avoided?:

Are there any other factors that are affecting recovery?:

If you have any questions regarding the information or would like to discuss, please contact the undersigned.

	( )	
Provider's Name	**Telephone Number**	**Date *(yyyy/mm/dd)***