Saskatchewan Workers' Compensation Board

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Website: www.wcbsask.com

TXP

Practitioner's Progress Report

Profession:

Part A: Patient Identification **WCB Claim Number:**

Last Name	First Name	Initial	Date of Birth (DD/MM/YY)	Personal Health Number

Worker's current complaints

Clinical findings

Describe other conditions not related to the work injury which may affect recovery

Progress towards treatment goals (Functional abilities required for return to work)

Identify any impediments to recovery

Treatment Plan

Worker is currently working ☐ **Yes** ☐ **No** **If no, expected return to work date**

If yes, has worker returned on a graduated return to work plan? ☐ **Yes** ☐ **No**

Expected length of program

Total appointments attended and dates:	**Dates absent:**	**Dates of treatment since last report:**
Date of next appointment:	**Frequency of appointments:**	**Expected discharge date:**

Part C: Practitioner Identification

Last name:	**First name:**
Signature:	**Date (DD/MM/YY)**

Part D: Clinic Identification

Clinic name:		**Clinic billing number:**	
Clinic address:	**City:**	**Province:**	**Postal code:**
Phone:	**Fax:**		

MISSION: ZERO