## Notification of Intake for Secondary or Tertiary Treatment Program

**Fax to:** Workers’ Compensation Board 306.787.4311 or 1.888.844.7773

### Treatment information

- **Name of treatment centre:**
- **Clinic phone number:**
- **Treatment clinic number (i.e., PHY, HSP):**
- **Treatment level (please check one):**
  - □ Secondary
  - □ Tertiary
- **Referred by:**
- **Program will begin on:**
- **Treatment schedule:**
  - □ From: ________ AM / PM
  - □ To: ________ AM / PM
  - □ Treatment time will vary
- **Referral date from WCB/primary caregiver:**

### Patient information

- **WCB claim number:**
- **Personal health number:**
- **Name of patient:**

### Expected treatment schedule

- □ Five days per week
- □ Other  
  - **Please specify:**

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**Signature**

**Date**

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**Updated:** 10/17

When writing to the WCB, please print claim or firm number.