WSCC Workers' Safety & Compensation Commission | ᐃᖃᓗᓇᐃᖅᑎᑐᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪᓗ ᓇᓕᓕᐅᔭᓄᑦ ᖃᐅᔨᓴᖅᑎᑦ

Hand Arm Vibration (HAV) Syndrome Assessment Form

COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS ON THE LAST PAGE. PLEASE PRINT.

WSCC Claim Number:	Health Care Provider (please print):

Worker Information

Last Name:	First Name:				
Mailing Address (include postal code):	Community:				Telephone (include area code):
Residential Address:	Date of Birth	YYYY	MM	DD	Gender: ☐ M ☐ F ☐ X
Employer's Name:	Worker's Occupation:				

PERIPHERAL VASCULAR ASSESSMENT

Symptoms? (vascular reactivity, timing, duration, anatomic sites)

Clinical Findings? (pulses, colour, trophic changes, edema)

PERIPHERAL NEUROLOGICAL ASSESSMENT

Symptoms? (quality, timing, duration, anatomic distribution)

Clinical Findings? (sensory and motor testing, reflexes)

EXTREMITY MUSCULO-SKELETAL/SKIN ASSESSMENT

Symptoms? (power, skin colour, temperature)

Clinical Findings? (ROM, atrophy, edema)

RELEVANT MEDICAL HISTORY

1) Concurrent disease(s) with vascular, neurological or musculo-skeletal sequelae?

2) Tobacco use? Current or past?

3) Current medication and/or herbal remedies?

4) Family history of Raynaud's Disorder?

5) Vibration exposures in non-occupational settings?

Worker's Name:	WSCC Claim Number:

Health Care Provider Information

Name of Health Care Provider (please print):	**WSCC Supplier Billing Number**
Telephone (include area code):	Fee Code _____ Fee Submitted _____ Fee Code _____ Fee Submitted _____
Address (include postal code):	Report Form Fee _____ Fee Submitted _____ **TOTAL $** 0.00
	Date of Exam: YYYY MM DD

Health Care Provider's Signature: _____ **Please print form to sign.** Date _____ _____ _____ (YYYY MM DD)

I hereby certify the above is a correct statement of services personally rendered by me.

RESPONSIBILITY OF HEALTH CARE PROVIDER

Excerpts from the Nunavut and Northwest Territories *Workers' Compensation Acts*:

Report by health care provider	25.	(1)	A health care provider who examines or treats a worker under this Act shall submit a report to the Commission.
Timing and contents of report		(2)	The report must be submitted within three days after the examination or treatment, and must contain the information required from the Commission.
Duty of health care facility		(3)	If a health care facility employs the health care provider referred to in subsection (1), the health care facility is responsible for ensuring that the report is submitted in accordance with this section.
Provision of information	30.		The Commission my require a claimant, an employer or a health care provider to provide any information that it considers necessary for it to determine a claim for compensation.

Excerpt from the Nunavut and Northwest Territories Workers' Compensation *General Regulations:*

	7.2	A health care provider who fails to provide information required under section 30 of the Acts is liable under subsection 141(2) to a penalty of $250.

The WSCC may use this information for the administration of legislation under our authority, including the *Workers' Compensation Acts*, the *Safety Acts*, and/or the *Mine Health and Safety Acts*, and their associated *Regulations*, and to contact you in relation to the requirements under the relevant legislation.

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Ce formulaire est disponible en français.