



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

Hand Therapy Evaluation Forms

Minjie Lin



Hand Therapy Evaluation Forms:

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