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wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail to:
200 Front Street W.
Toronto ON
M5V 3J1

Fax to:
416-344-4684 or
1-888-313-7373

Musculoskeletal Program of Care (MSKPOC) Initial Assessment Report

Claim Number

For an injury to: (select one) ☐ Upper body (excluding the shoulder)
☐ Lower body (excluding the lower back)

Please PRINT in black ink.

A. Worker & Employer Information Section

Last Name	First Name	Init.
Address (no. street, apt.)		
City/Town	Prov. / Postal Code	Telephone ( )
Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)	Sex ☐ M ☐ F
Employer Name	Supervisor/Contact Name	Telephone No. ( )
Worker's Current Job Title/Occupation	Length of time in current job: months / years	

Employment status at time of assessment:

☐ Full time **OR** ☐ Part time ☐ Not working
☐ Regular duties **OR** ☐ Modified duties Please ask the worker before assessment:
☐ Regular hours **OR** ☐ Modified hours If not working, how long do you think you will be off work? _____ days

B. Health Professional Information

☐ Chiropractor ☐ Physiotherapist ☐ Other, please specify: _____

Health Professional Name (please print)	Facility Name		
Address (no. street, apt.)	City/Town	Prov.	Postal Code
Telephone ( )	Date of initial assessment (dd/mmm/yyyy)		

C. Clinical Information

1. Name of the referring health professional (if applicable)	2. Date of referral (dd/mmm/yyyy)
3. Worker's history of injury:	
4. Area(s) of injury:	
5. Pertinent Clinical Signs:	
6. Working Diagnosis:	
7. Additional information:	

Worker's Last Name	Worker's First Name
Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)

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D. Functional Information

Administer and record the scores for the Patient-Specific Functional Scale (PSFS) for 3-5 functional activities at least 2 of which are work-related. The PSFS is available on the WSIB web site at **www.wsib.on.ca**.

	Functional Activity	Score	Relevant Physical Demands/Functional Requirements	Clinician's Assessment of Current Ability
E.g.	*Lift from floor level*	*/10*	*Lift 30 lb box from floor level, using both hands.*	*Can lift 10 lbs from 8" elevation to hip level.*
1.		*/10*		
2.		*/10*		
3.		*/10*		
4.		*/10*		
5.		*/10*		
	Total: Divide the total score by the number of activities (minimum of 3 activities)	*/10*		

Have you identified any factors that may delay recovery or Return to Work? ☐ Yes ☐ No

If yes, please describe:

E. Treatment Plan & Return to Work Recommendations

1. Considering your assessment findings, what are your recommendations for work activities?

Regular duties	☐ Yes	☐ No	If no, enter expected date (dd/mmm/yyyy) →
Modified duties	☐ Yes	☐ No	If no, enter expected date (dd/mmm/yyyy) →
Regular hours	☐ Yes	☐ No	If no, enter expected date (dd/mmm/yyyy) →
Modified hours	☐ Yes	☐ No	If no, enter expected date (dd/mmm/yyyy) →

2. Please estimate the frequency of visits that is appropriate for this worker: ____ per week

3. Please estimate the length of care that will be required for this worker: ____ weeks

Health Professional Signature	Date (dd/mmm/yyyy)

Type your name and upload, or print and sign before returning to WSIB.

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