

A. Injured person information		
Last name	First name	
Date of birth (dd/mm/yyyy)	Date of injury (dd/mm/yyyy)	Date of initial assessment (dd/mm/yyyy)
Submit this form when the person has completed the interdisciplinary team program of care or when discharged.		
Injured person has completed this program of care	Injured person did not return/self-discharged	
Area(s) being treated:	Current employment status:	
	At work	Off work
Supplementary block number:	Number of sessions provided in supplementary block:	

B. Regulated health professional information			
Team lead name and profession		Other team member(s) name and profession	
Facility name		Telephone	WSIB provider ID
Address (number, street, unit/suite)	City/town	Province	Postal code
Date of report (dd/mm/yyyy)		Date of last treatment session (dd/mm/yyyy)	

C. Clinical information						
<p>1. What treatment interventions have you delivered?</p>						
<p>2. Overall, response to treatment to date:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; text-align: center; padding: 5px;">Fully recovered (from workplace injury)</td> <td style="width: 33%; text-align: center; padding: 5px;">Significant improvement</td> <td style="width: 33%; text-align: center; padding: 5px;">Moderate improvement</td> </tr> <tr> <td style="text-align: center; padding: 5px;">Minimal improvement</td> <td style="text-align: center; padding: 5px;">No improvement</td> <td style="text-align: center; padding: 5px;">Worsening</td> </tr> </table> <p>Provide details on treatment goals and progress:</p>	Fully recovered (from workplace injury)	Significant improvement	Moderate improvement	Minimal improvement	No improvement	Worsening
Fully recovered (from workplace injury)	Significant improvement	Moderate improvement				
Minimal improvement	No improvement	Worsening				

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.
 Ce document est disponible en français sous le titre : *Programme de soins assuré par une équipe interdisciplinaire : Rapport complémentaire – Conditionnement au travail, 10715B (11/23)*

Last name	First name
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C. Clinical information (continued)

3. Describe the person's current symptoms:

4. Describe any impact on functional status (social, occupational, personal):

5. Identify and describe any psychosocial stressors impacting recovery, if present:

6. Summary of physical assessment findings (include examination findings for all areas of injury):

Testing	Findings and details (include relevant negative findings)					
Hand dominance	Right-handed		Left-handed		Ambidextrous	

Observation and palpation (e.g., posture, gait, immobilization status)	
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Area of body/joint movement	Initial assessment						Current assessment					
	Active range of motion		Passive range of motion		Strength testing		Active range of motion		Passive range of motion		Strength testing	
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left

Limiting factor(s)/comments:

Neurological testing (e.g., sensory, motor reflexes, neurodynamic testing):

Last name	First name
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C. Clinical information (continued)

Relevant orthopedic/special testing:

Other (specify):

D. Outcome measures

Complete at least one functional outcome measure that relates to the person's area(s) of injury. Repeat the same outcome measure(s) throughout the treatment period.

	Initial assessment score	Current score
Neck Disability Index (NDI) Level of disability: 0 to 4 (0-8%) = none; 5 to 14 (10-28%) = mild; 15 to 24 (30-48%) = moderate; 25 to 34 (50-64%) = severe; above 34 (70-100%) = complete disability	_____ %	_____ %
Oswestry Low Back Pain Disability Questionnaire (ODI 2.1a version) Level of disability: 0-20% = minimal; 21-40% = moderate; 41-60% = severe disability; 61-80% = crippled; 81-100% = bed bound/exaggerating symptoms	_____ %	_____ %
QuickDASH Disability/Symptom QuickDASH Work Module The higher the score, the greater the disability	_____ /100 _____ /100	_____ /100 _____ /100
Lower Extremity Functional Scale (LEFS) The lower the score, the greater the disability	_____ /80	_____ /80
World Health Organization Disability Assessment Schedule (WHODAS 2.0-12 item version) The higher the score, the greater the disability	_____ /48	_____ /48

Where clinically indicated, complete the applicable anxiety/mood/pain measure(s). Repeat as needed throughout the treatment period.

Generalized Anxiety Disorder-7 (GAD-7) Level of anxiety symptoms: 0 to 9 = none to mild; 10 to 14 = moderate; 15 to 21 = severe	_____ /21	_____ /21
Patient Health Questionnaire-9 (PHQ-9) Level of depressive symptoms: 0 to 4 = none; 5 to 9 = mild; 10 to 14 = moderate; 20 to 27 = severe	_____ /27	_____ /27
Pain Self-Efficacy Questionnaire (PSEQ) Lower scores indicate lower self-efficacy and lower levels of confidence in dealing with pain	_____ /60	_____ /60

Comments (provide interpretation, key findings, etc. from outcome measures used):

Last name	First name
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E. Diagnosis and prognosis

1. Provide occupational diagnosis(es) and prognosis(es):

Diagnosis(es)	Prognosis e.g., expecting full functional recovery; expecting partial recovery; not expecting further recovery	Expected timeframe and rationale Support with clinical findings and recovery barriers

2. Are there any factors that may delay the person's recovery and their return to work? Yes No

If **yes**, indicate below:

- Fear/avoidance of activity
- Co-morbid conditions
- Limited support
- Believes hurt equals harm
- Low mood

- Does not feel ready to return to work
- "Medium to heavy" job duties
- Working conditions and/or shift work
- Difficulty transitioning from modified to pre-injury duties
- Does not feel current work duties are suitable

Other (please specify):

F. Occupational status

Current work hours:	At work - full hours	At work - partial hours	Off work
Current work duties:	Pre-injury job	Pre-injury job accommodated	Alternate work Off work
Is the person managing with their current work duties?	Yes	No	N/A

If **no**, provide details below:

Have you reviewed a meeting memo/plan from a WSIB Return-to-Work Specialist to develop the work hardening protocol?

Yes No

If **no**, provide details below:

Last name	First name
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G. Work hardening/functional testing

Essential job duties of concern and relevant physical demands (e.g., force, posture, frequency, distance)	Abilities - previous report assessment (dd/mm/yyyy)	Abilities - supplementary block number (dd/mm/yyyy)	Observations/comments (document relevant findings)
E.g., Load/unload orders: Front-lifting up to 20 lbs from floor to shoulder level on an occasional basis	E.g., Front-lifting up to 10 lbs from waist to shoulder level on occasional basis	E.g., Able to front-lift up to 20 lbs from floor to shoulder level on occasional basis	E.g., Achieved and able to complete relevant physical demands for this duty
1)			
2)			
3)			
4)			
5)			

* Occasional (1-33% of the workday); Frequent (34-66% of the workday); Constant (67-100% of the workday)

H. Additional referral and recovery recommendations

1. Are you recommending any additional referral(s) for assessment or intervention? We can help the person access other services, where appropriate. Yes - provide details below No

2. Are you recommending a supplementary block of treatment?
 Yes - please call us for pre-approval No - no further treatment needed

If **yes**, indicate the rationale for additional treatment and goals:

Last name	First name
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H. Additional referral and recovery recommendations (continued)

Estimated frequency of treatment: _____ times per week

Estimated duration of treatment: _____ weeks | Requested supplementary block start date: _____

3a. Did you communicate with other treating health care professionals (e.g., musculoskeletal program of care provider, other contracted providers, orthopedic surgeon, family physician, etc.)?

Yes No N/A

If **yes**, outline discussion:

3b. Did you communicate with a WSIB Return-to-Work Specialist?

Yes No N/A

If there are questions or concerns about the information provided in this report, please call _____ at _____.

I. Signatures

Team lead regulated health professional name and signature	Regulated health professional name and signature
Date (dd/mmm/yyyy)	Date (dd/mmm/yyyy)

Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

Last name	First name
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J. Abilities and restrictions for return-to-work planning

Abilities		
Walking: Full abilities Up to 100 metres 100-200 metres Other (specify):	Standing: Full abilities Up to 15 minutes 15-30 minutes Other (specify):	Sitting: Full abilities Up to 30 minutes 30 minutes-1 hour Other (specify):
Stair climbing: Full abilities Up to 5 steps 5-10 steps Other (specify):	Lifting from floor to waist: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):	Lifting waist to shoulder: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):
Lifting above shoulder: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):	Pushing/pulling: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):	Ladder climbing: Full abilities 1-3 steps 4-6 steps Other (specify):
Ability to drive a car: Yes No – please explain:		Ability to use public transit: Yes No – please explain:

Restrictions None

Bending/twisting repetitive movement of (please specify):

Frequency: Occasional (1-33%) Frequent (34-66%) Constant (67-100%)

Last name	First name
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J. Abilities and restrictions for return-to-work planning (continued)

Restrictions

Use of hand(s):

Left	Right
Gripping	
Pinching	
Other (please specify):	

Frequency: Occasional (1-33%) Frequent (34-66%) Constant (67-100%)

Operating motorized equipment (e.g., forklift):

Chemical exposure to:	Environmental exposure to (e.g., heat, cold, noise or scents):	Potential side effects from medications (please specify):	Exposure to vibration:
		Note: do not include the name of medications.	Whole body Hand/arm

Additional comments on abilities and restrictions:

Estimated time frame for abilities and restrictions:

Summarize changes in functional abilities since previous report:

K. Signature

Team lead regulated health professional name and signature	Date (dd/mmm/yyyy)
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Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.