WSIB Ontario | Physiotherapy assessment report

Claim number

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Patient information			
Last name	First name		Initials
Address	City	Province	Postal code
Date of birth	Telephone	Sex ☐ Male ☐ Female	

Employer information			
Employer name			
Address	City	Province	Postal code
Telephone	Fax	Date of accident (dd/mmm/yyyy)	

1. Date of initial assessment (dd/mmm/yyyy)	Name of referring health professional
2. Patient's history of injury	
3. Physical findings	
4. Working diagnosis	
5. Is treatment required? ☐ Yes ☐ No	If **yes**, describe the goals for treatment and approximate duration/frequency of treatment
6. Treatment program proposed	Can the patient work while participating in treatment? ☐ Yes ☐ No
7. Are there any physical restrictions that should be observed? ☐ Yes ☐ No	If **yes**, what are they?
8. Complete recovery expected? ☐ Yes ☐ No	If yes, approximately when?
9. Describe any factors (including pre-existing or underlying conditions) which may delay recovery.	

Physiotherapist's name			Service Code **P970**
Address		City/Town	WSIB provider ID
Province	Postal code	Telephone	**Complete these fields if HST is applicable to this form**
Physiotherapist's signature		Date (dd/mmm/yyyy)	HST registration number / Service code **ONHST** / HST amount billed
			Service date (dd/mmm/yyyy)
			Your invoice number

☐ 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.

Email accessibility@wsib.on.ca if you need a different format or accommodation. Disponible en français.