WSIB Ontario | Mild traumatic brain injury program of care (mTBI POC) initial assessment report

Claim number

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A. Injured person and employer information

Last name	First name	Initials

Address (number, street, unit/suite)

City/town	Province	Postal code	Telephone

Date of birth (dd/mmm/yyyy)	Date of accident (dd/mmm/yyyy)

Employer name	Supervisor/contact name	Telephone

Injured person's job title/occupation	Approximate length of time in current job : months	years

Employment status at time of assessment:

A. ☐ Full time **or** ☐ Part time

B. ☐ Regular duties **or** ☐ Modified duties

C. ☐ Regular hours **or** ☐ Modified hours

If working modified duties or hours, please ask the injured person how long they think it will take to return to full hours / full duties _____ days

☐ Not working

If not working, please ask the injured person when they expect to return to work _____ days

B. Regulated health professional information

☐ Chiropractor ☐ Occupational Therapist ☐ Physiotherapist ☐ Other (specify) _____

Name	Date of report (dd/mmm/yyyy)
Facility name	Date(s) of this assessment (dd/mmm/yyyy)
Address (number, street, unit / suite)	WSIB provider ID
City/town / Province	Service code **MTBRIAF**
Postal code / Telephone	Complete these fields if HST is applicable to this form
	HST registration number / Service code **ONHST**
	HST amount billed

C. Clinical information

1. Name regulated health professional/facility who provided mTBI/concussion diagnosis:	Date of diagnosis (dd/mmm/yyyy)

Select: ☐ Physician ☐ Nurse practitioner ☐ Occupational Health Assessment Program (OHAP), mTBI physician

2. Injured person's history of injury (provide details regarding mechanism of injury/description of accident):

Loss of consciousness:	☐ yes	☐ no	If yes,	Minutes
Amnesia:	☐ yes	☐ no		
Early onset of headaches:	☐ yes	☐ no		

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C. Clinical information (continued)

3. Previous history of:

Concussion/head injury:	☐ yes	☐ no	If yes,	Number of mTBIs within previous 12 months
Mental health concerns or condition:	☐ yes	☐ no		
Substance use disorder:	☐ yes	☐ no		
Neurological condition(s):	☐ yes	☐ no		

Provide details regarding any conditions/disorders identified above. Include other relevant and/or pre-existing medical information (include prescribed medication(s), over the counter medications/supplements and substance use, including alcohol, marijuana and other recreational drugs):

4. Investigations, consultations, and treatment to date (provide details):

5. Summary of self-reported symptoms:

Ask the injured person to comment on the three most troublesome symptoms (e.g. intensity, frequency, duration, progression, triggers, aggravating factors)

Symptom	Description
1.	
2.	
3.	

Were these symptoms present prior to the mTBI? ☐ yes ☐ no

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6. Summary of physical findings (including pertinent negative findings):

Testing	Normal exam	Findings and details
Musculoskeletal	☐ yes ☐ no	
Neurological	☐ yes ☐ no	
Balance	☐ yes ☐ no	
Vestibular	☐ yes ☐ no	
Other (specify)	☐ yes ☐ no	
Mental status and cognition:		
Functional status/exercise testing (if appropriate):		

7. Rivermead Post-Concussion Symptoms Questionnaire:

Total all scores excluding “other difficulties”. The Rivermead is available at www.wsib.ca. Score: /64

Comments:

8. Working diagnosis(es):

☐ mTBI/concussion ☐ Other:

Comments:

9. In your assessment, did you observe/identify any complicating factors that may delay recovery? ☐ yes ☐ no

If **yes**, please identify:

☐ Believes hurt equals harm
☐ Fears/avoids activity
☐ Low mood/social withdrawal
☐ Prefers passive treatments
☐ Home environment concerns
☐ Changes in relationship dynamics
☐ Work environment concerns
☐ Other (specify):

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10. Check all affected activities of daily living:

- ☐ Self care
- ☐ Meal preparation
- ☐ Shopping (groceries)
- ☐ Child care/care giving
- ☐ Housekeeping
- ☐ Household maintenance (e.g. outdoor maintenance, snow shovelling)
- ☐ Driving
- ☐ Leisure activities/sports
- ☐ Communication
- ☐ Computer/television use
- ☐ Reading

Comment on affected activities of daily living (e.g., current limitations compared with abilities prior to date of injury):

D. Functional information

11. Administer and record the scores for the Patient-Specific Functional Scale (PSFS) for three to five functional activities, at least two of which are work-related. The PSFS is available at www.wsib.ca.

Functional activity		Score	Relevant physical demands / functional requirements	Clinician's assessment of current ability
E.g.	Lift from floor level	3/10	Lift 30 lb box from floor level, using both hands.	Can lift 10 lb 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 three activities)		/10		

E. Abilities, limitations and accommodations for return-to-work planning

12. Provide the injured person's functional abilities, limitations, restrictions and accommodations to facilitate return to work.

Physical	Limitations	Describe recommended accommodation
Sit/stand (duration of each / frequency of change)	☐ yes ☐ no ☐ na	
Lifting (weight/frequency, own pace or high demand)	☐ yes ☐ no ☐ na	
Walking (distance/time)	☐ yes ☐ no ☐ na	
Carrying	☐ yes ☐ no ☐ na	
Other (specify):	☐ yes ☐ no ☐ na	

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Potential mTBI symptom triggers	Limitations	Describe recommended accommodation
Computer work (duration, frequency of breaks / other tasks)	☐ yes ☐ no ☐ na	
Visual tasks (reading, non-computer tasks)	☐ yes ☐ no ☐ na	
Lighting (brightness, fluorescent, etc.)	☐ yes ☐ no ☐ na	
Noise (continuous, impact, other)	☐ yes ☐ no ☐ na	
Interaction with public	☐ yes ☐ no ☐ na	
Interaction with co-workers	☐ yes ☐ no ☐ na	
Other (specify):	☐ yes ☐ no ☐ na	
Safety considerations	**Limitations**	**Describe recommended accommodation**
Work at heights	☐ yes ☐ no ☐ na	
Driving	☐ yes ☐ no ☐ na	
Operating machinery	☐ yes ☐ no ☐ na	
Other (specify):	☐ yes ☐ no ☐ na	

F. Treatment plan and additional referral recommendations

13. Indicate expected treatment interventions:

☐ Education
☐ Gradual integration of activity
☐ Progressive exercise therapy (including balance & coordination exercises), such as the Buffalo Concussion Treadmill Test
☐ Manual therapy
☐ Vestibular rehabilitation, provide objective findings from assessment, rationale for treatment and planned interventions:

☐ Other (specify):

Expected treatment duration and frequency

Estimated duration of treatment : weeks

If you anticipate more than eight weeks of treatment, please provide rationale:

Estimated frequency of treatment: times per week

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Initial education

Did the injured person appear to understand the mTBI information/education shared? ☐ yes ☐ no

Did you provide written education materials? ☐ yes ☐ no

Topics discussed:

- ☐ Concussion knowledge
- ☐ Symptom interpretation
- ☐ Recovery expectations
- ☐ Anxiety levels
- ☐ Managing symptoms
- ☐ Other (specify):

14. Are you recommending additional referrals? ☐ yes ☐ no If **yes**, indicate below

- ☐ WSIB Community Mental Health Program (psychology)
- ☐ Psychiatry
- ☐ WSIB OHAP mTBI Assessment
- ☐ WSIB Neurology Specialty Program
- ☐ Other WSIB Specialty Programs
- ☐ WSIB Return to Work Specialist
- ☐ Other (specify):

Reason for referral:

15. Other comments:

mTBI POC regulated health professional signature	Date (dd/mmm/yyyy)