

Musculoskeletal (MSK) program of care: Supplementary report

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Visit wsib.ca/submit to submit this form and supporting documents.

lnj	ury to:	Single MSK zone	Single MSK zone Multiple MSK zones (approval required)						
Α.	Injured pe	rson information							
	st name					First name			
Da	te of birth	(dd/mm/yyyy)	Date of i	njury (dd	/mm/y	yyy) Date of i		of initial assessment (dd/mm/yyyy)	
		red person has completed supplementary block.	I MSK pro	gram of		Injured	person di	d not retu	rn/self-discharged.
Cu	rrent emp At w	oloyment status: vork Off work				Number of ses	ssions pro	vided in s	supplementary block:
R	Regulated	health professional inforr	nation						
	me	Theurin professional finori	iiutioii	Profess	ion				WSIB provider ID
Fa	cility nam	e			Telep	phone		Date of r	eport (dd/mm/yyyy)
Ad	dress (nu	mber, street, unit/suite)							
City/town		Province Pos		Posta	stal code Date of		of last treatment session (dd/mm/yyyy)		
C.	Clinical in	formation							
1.	Response	e to treatment to date:	Fully recovered (from workplace injury) Significant improvement				•		
Đ۳	ovide deta	aile:	Minim	nal impro	vemer	nt No imp	provement	: Wo	orsening
r IV	JVIUE UELE	allo.							
2.	Summary	of physical assessment f	indings (in	clude ex	amina	tion findings fo	r all areas	of injury)	 :
Testing Findings and details (include pertinent neg Hand dominance Right handed Left handed					and details (incl				
		ion (e.g., posture, gait, ration status)							

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La	ast name	First name	Date of birth (dd/mm/yyyy)
C.	Clinical information (continued)		
2.	Summary of physical assessment finding	s (include examination findings for all a	areas of injury):
	Testing	Findings and details (include	pertinent negative findings
	Palpation and range of motion (ROM): (e.g., tenderness on palpation, passive ROM, active ROM, resisted ROM, etc.)		
	Neurological testing: (e.g., sensory, motor reflexes, strength, neurological tests as needed)		
	Relevant orthopedic/ special testing		
	Other (specify)		
3.	Provide occupational diagnosis(es):		
4.	Are there any factors that may delay the i	njured person's recovery and their retu	urn-to-work?
	Yes No		
	If yes , indicate below:		
	Fear/avoidance of activity Co-morbid conditions Limited support Believes hurt equals harm Low mood/social withdrawal		b duties
Ot	ther (specify):		

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Ontario					
Last name	First name	Date of birth (dd/mm/yyyy)			
D. Outcome measures					
1. Complete at least one functional o measure(s) should be repeated throu	utcome measure that relates to the injured persor ughout the treatment period.	n's area(s) of injury. The same outcome			
F	Score				
Neck Disability Index (NDI)	Neck Disability Index (NDI)				
Oswestry Low Back Pain Dis	sability Questionnaire (ODI 2.1a version)	%			
QuickDASH Disability/Symp	QuickDASH Disability/Symptom				
QuickDASH Work Module		/100			
Lower Extremity Functional	Scale (LEFS)	/80			
World Health Organization D (WHODAS 2.0-12 item versi	Disability Assessment Schedule on)	/48			

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

E.	Additional	referral	and	recovery	recommend	lations

1. Are you recommending any additional referral for assessment or intervention? Where determined appropriate for the
occupational injury, the WSIB will assist in facilitating access.

Yes - provide details below

No

2. Are you recommending a supplementary block of treatment?

Yes - Contact the WSIB

No - No further treatment needed

If **yes**, indicate treatment frequency, duration and recovery and return-to-work goals:

3. Have you discussed returning to work with the injured person?

Yes

Outline discussion:

Regulated health professional signature

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.

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Last name	First name	First name		
Regulated health professional last name	Regulated health prof	essional first name	Date of this assessment (dd/mm/yyyy	
Abilities and restrictions for return-to-work	planning			
Abilities				
Walking:	Standing:		Sitting:	
Full abilities	Full abilities		Full abilities	
Up to 100 metres	Up to 15 minutes	6	Up to 30 minutes	
100-200 metres	15-30 minutes		30 minutes-1 hour	
Other (specify):	Other (specify):		Other (specify):	
Stair climbing:	Lifting from floor t	o waist:	Lifting waist to shoulder:	
Full abilities	Full abilities		Full abilities	
Up to 5 steps	Limited – 0-5kg		Limited – 0-5kg	
5-10 steps	Light – 5-10kg		Light – 5-10kg	
Other (specify):	Medium – 10-20l	kg	Medium – 10-20kg	
	Heavy >20kg		Heavy >20kg	
	Other (specify):		Other (specify):	
Lifting above shoulder:	Pushing/pulling:		Ladder climbing:	
Full abilities	Full abilities		Full abilities	
Limited – 0-5kg	Limited – 0-5kg		1-3 steps	
Light – 5-10kg	Light – 5-10kg		4-6 steps	
Medium – 10-20kg	Medium – 10-20kg		Other (specify):	
Heavy >20kg	Heavy >20kg		· · · · · · · · · · · · · · · · · · ·	
Other (specify):	Other (specify):			
Ability to drive a car:		Ability to use pub	olic transit:	
Yes		Yes		
No – please explain:		No – please exp	olain:	
Restrictions None				
Bending/twisting repetitive move	ment of (please specify	y):		
Frequency: Occasional (1-33%) Frequent (34-6	66%) Consta	ant (67-100%)	

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fill out your name and the date above.

Last name		First name			Date of birth (dd/mm/yyyy)	
Regulated health professional last	name Re	gulated health profession	al first name	Date of thi	s assessment (dd/mm/yyyy)	
Abilities and restrictions for return-	-to-work plan	ning (continued)		1		
Restrictions	oo morni primi	g (commutat)				
Use of hand(s):						
Left	Rig	jht				
Gripping						
Pinching						
Other (please sp	ecify):					
Frequency: Occasional	(1-33%)	Frequent (34-66%)	Consta	ant (67-100	%)	
Operating motorized equi	pment (e.g.,	forklift):				
		·				
Work at heights:			Expos	ure to vibr	ation:	
			Whole body I			
Additional comments on abilities	s and restr	ictions:				
Estimated time frame for above	abilities an	d restrictions:				
Summarize changes in function	al abilities	since last report:				
_		-				
Regulated health professional sign	nature			ח	ate (dd/mmm/yyyy)	
. Logaratou Houritt professional sign	.a.a.o				a.o (aa/iiiiii/yyyy)	
Check this box if you are co	mnleting and	d submitting this form elec	tronically This	renresent	vour signature. Vou must	

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