WSIB Ontario | Health professional continuity report (Form REO8)

Claim number

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

Section 37 of the Workplace Safety and Insurance Act authorizes you to release this information to the WSIB.

Original date of accident/injury

Patient's name

Service date dd mm yy

Date of recurrence/re-injury

1. Provide the patient's history regarding the recurrence/re-injury of the work-related condition.

2. Have you previously assessed or treated the patient for this condition between and ? ☐ Yes ☐ No
If **yes**, list dates of treatment.

3. Has the patient been seen by another health professional between and ? ☐ Yes ☐ No ☐ Unknown
If **yes**, provide names and dates (if known).

4. Since , have there been any further injuries that have affected your patient's work-related condition? ☐ Yes ☐ No
If **yes**, provide details.

5. Between and , have you continued to prescribe medications and/or assistive devices/braces for the patient? ☐ Yes ☐ No
If **yes**, provide details.

6. a) Patient's present complaints/symptoms (e.g. pain, swelling, weakness, etc.)

b) Objective findings/signs (e.g. crepitation, wasting, range of motion, etc.)

7. Current/working diagnosis

8. Are there any complicating factors that may influence your patient's recovery and/or return to work? ☐ Yes ☐ No
If **yes**, provide details.

9. Please indicate patient's status and task limitations in relation to diagnosis. If you have been asked to complete a WSIB Functional Abilities Form (FAF) at the same time as this Form REO8, you do not need to complete Questions 9 & 10.

A) ☐ **No limitations**
B) ☐ **Limitations** (as specified)
C) ☐ **Other** (explanation required)

☐ Standing ☐ Climbing stairs/ladders ☐ Use of public transportation
☐ Sitting ☐ Use of upper extremities ☐ Operation of a motor vehicle
☐ Lifting ☐ Operating heavy equipment ☐ Medication
☐ Bending/lifting ☐ Limitations due to environmental conditions ☐ Other:
☐ Kneeling ☐ Personal protective equipment

Explanation/additional details:

*Have you and your patient discussed return to work? ☐ Yes ☐ No

10. From the date of this assessment, the above task limitations will apply for approximately:
☐ 1-2 days ☐ 3-7 days ☐ 1 wk ☐ 2 wks. ☐ 3+ wks

11. Next appointment: ☐ none required ☐ <1 wk ☐ 1 wk ☐ 2 wks ☐ 3+ wks

It is an offense to knowingly make a false or misleading statement or representation to the WSIB.
I declare that the information being submitted is true and complete.

☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered nurse (extended class)

Health professional name

Address (no., street, apt)

City/town	Prov.	Postal code	Telephone	Fax

Health professional's signature (print, sign and return to the WSIB or type and upload)

Date (dd/mm/yy)

Service code **8R**

Complete these fields if **HST** is applicable to this form.

HST Registration No.

Service code **ONHST**

HST amount billed
$

WSIB Provider ID.

Your Invoice No.

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