Mail To:
200 Front Street West
Toronto, ON M5V 3J1

OR

Fax To:
416-344-4684
1-888-313-7373

Please PRINT in black ink.

Chiropractor's Treatment Extension Request

Claim Number

Patient Information

Last Name		First Name		Initials
Address		City	Prov.	Postal Code
Telephone		Date of Birth (dd/mmm/yyyy)		Sex ☐ M ☐ F
Date of worker's first treatment (dd/mmm/yyyy)		Date of assessment on which this report is based (dd/mmm/yyyy)		

Message to Chiropractor:

- Chiropractic treatment will not be paid for beyond 12 weeks unless an extension is pre-authorized by the WSIB.
- To ensure continuity of treatment, this document must be completed in full and submitted to the WSIB at least 4 weeks prior to the completion of the 12 week treatment period.
- Section 37 of the Workplace Safety and Insurance Act authorizes you to release this information to the WSIB.

Working diagnosis	Any change from initial diagnosis: ☐ yes ☐ no If **yes**, what is new working diagnosis:
Case summary/treatment to date	Results of treatment to date: (ie. degree of improvement, effects on ADLs, etc.)

Has worker lost time as a result of the accident? ☐ yes ☐ no	Has worker returned to regular work? ☐ yes ☐ no	Has worker returned to modified work? ☐ yes ☐ no

Present Status	**Expected Outcomes with Additional Treatments**
Current symptoms and findings on examination: (ROM, neurological testing, etc.)	Expected improvements in examination findings and limitations:
Current functional limitations:	Complete recovery expected: ☐ yes ☐ no If **yes**, approximate date: (dd/mmm/yyyy)
Factors delaying recovery:	Duration of Treatment Required: Start date: (dd/mmm/yyyy) End date: (dd/mmm/yyyy) Estimated frequency of further treatment:

Would the worker benefit from a multi-disciplinary health care assessment? ☐ yes ☐ no

Chiropractor Information

Chiropractor's Name (please print)	Clinic Name		
Address	City/Town	Prov.	Postal Code
Telephone	Signature	Date (dd/mmm/yyyy)	