WSIB ONTARIO CSPAAT

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

OR FaxTo:
416-344-4684
OR 1-888-313-7373

REO8

Health Professional Continuity Report (Form REO8)

Claim Number	Desk No.	Alloc. No.
##########	#####	###

Section 37 of the Workplace Safety and Insurance Act authorizes you to release this information to the WSIB. Please respond to all questions in black ink and return by fax to (416) 344-4684 or 1-888-313-7373.

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
- ☐ Sitting
- ☐ Lifting
- ☐ Bending/Twisting
- ☐ Kneeling
- ☐ Climbing Stairs/Ladders
- ☐ Use of Upper Extremities
- ☐ Operating Heavy Equipment
- ☐ Limitations Due To Environmental Conditions
- ☐ Personal Protective Equipment
- ☐ Use of Public Transportation
- ☐ Operation of a Motor Vehicle
- ☐ Medication
- ☐ Other _____

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 (please print)

Address (no., street, apt.)

City/Town	Prov.	Postal Code	Telephone

Health Professional's Signature	Date (dd/mm/yy)	Fax

Service Code: **8R**

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

HST Registration No.	Service Code	HST Amount Billed
	ONHST	$.

WSIB Provider ID.

Your Invoice No.