

A. Injured person information				
Last name		First name		Initials
Date of birth (dd/mmm/yyyy)		Date of injury (dd/mmm/yyyy)		Date(s) of initial assessment (dd/mmm/yyyy)
Injured person completed supplementary block Injured person did not return/self-discharged		Number of sessions provided in this block:		
Employment status at time of discharge:				
A.	Full time	or	Part time	Not working
B.	Regular duties	or	Modified duties	
C.	Regular hours	or	Modified hours	

B. Regulated health professional information				
Chiropractor	Occupational Therapist	Physiotherapist	Other (specify) _____	
Name			Date of report (dd/mmm/yyyy)	
Facility name			Date of last treatment (dd/mmm/yyyy)	
Address (number, street, unit / suite)			WSIB provider ID	
City/town		Province	Service code MTBRST or MTBRSTV	
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. Has the injured person returned to their pre-injury level of function?	yes no
List any outstanding issues and/or symptoms:	
2. Additional investigations and consultations since the initial assessment (provide details):	
3. Response to treatment	
Fully recovered	Significant improvement Minimal improvement No improvement Worsening
Provide details:	

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

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D. Functional information

8. 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	COS score	Current score	Relevant physical demands / functional requirements	Clinician's assessment of current ability
E.g. Lift from floor level	3/10	10/10	Lift 30 lb box from floor level, using both hands.	Lift 30 lb box from floor level, using both hands.
1.	/10	/10		
2.	/10	/10		
3.	/10	/10		
4.	/10	/10		
5.	/10	/10		
Total: Divide the total score by the number of activities (minimum three activities)	/10	/10		

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

9. 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. Additional referral recommendations

10. 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, mTBI Assessment	Other WSIB Specialty Programs WSIB Return to Work Specialist Other (specify):
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Reason for referral:

11. Other comments:

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