Interdisciplinary team program of care: Mid-point report – work hardening

Submit this form and supporting documents at wsib.ca/submit

Claim number

A. Injured person information		
Last name	First name	
Date of birth (dd/mm/yyyy)	Date of injury (dd/mm/yyyy)	Date of initial assessment (dd/mm/yyyy)
Complete this report at the end of block one.		
Area(s) being treated	Current employment status: ☐ At work ☐ Off work	Number of sessions provided in block one:

B. Regulated health professional information			
Team lead name and profession	Other team member(s) name and profession		
Facility name	Telephone	WSIB provider ID	
Address (number, street, unit/suite)	City/town	Province	Postal code
Date of report (dd/mm/yyyy)	Date of last treatment session (dd/mm/yyyy)		

C. Progress to date

1. What treatment interventions have you delivered?

2. Overall, response to treatment to date:

☐ Fully recovered (from workplace injury) ☐ Significant improvement ☐ Moderate improvement

☐ Minimal improvement ☐ No improvement ☐ Worsening

Provide details on treatment goals and progress:

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

Ce document est disponible en français sous le titre : *Programme de soins assuré par une équipe interdisciplinaire : Rapport de mi-parcours – Conditionnement au travail*, 10711B (11/23).

Last name	First name

D. Work hardening/functional testing

Essential job duties of concern and relevant physical demands (e.g., force, posture, frequency, distance)	**Abilities initial assessment**	**Current abilities**	**Observations/comment** (document relevant findings)
E.g., Load/unload orders: Front-lifting up to 20 lbs from floor to shoulder level on an occasional basis	E.g., Able to front-lift up to 5 lbs from waist to shoulder level on occasional basis	E.g., Able to front-lift up to 10 lbs from waist to shoulder level on occasional basis	E.g., Pain reported in bilateral shoulders, rest break required after first lift
1)			
2)			
3)			
4)			
5)			

*Occasional (1-33% of the workday); Frequent (34-66% of the workday); Constant (67-100% of the workday)

E. Additional referral and recovery recommendations

1. Are there any factors that may delay the person's recovery and their return to work? ☐ Yes ☐ No

If **yes**, indicate below:

- ☐ Fear/avoidance of activity
- ☐ Co-morbid conditions
- ☐ Limited support
- ☐ Believes hurt equals harm
- ☐ Low mood
- ☐ Does not feel ready to return to work
- ☐ Medium to heavy job duties
- ☐ Working conditions and/or shift work
- ☐ Difficulty transitioning from modified to pre-injury duties
- ☐ Does not feel current work duties are suitable

Other (please specify):

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Last name	First name

E. Additional referral and recovery recommendations (continued)

2. Are you recommending any additional referral(s) for assessment or intervention? We can help the person access other services, where appropriate. ☐ Yes, provide details below: ☐ No

3a. Did you communicate with other treating health care professionals (e.g., musculoskeletal program of care provider, other contracted providers, orthopedic surgeon, family physician, etc.)?

☐ Yes ☐ No ☐ N/A

If **yes**, outline discussion:

3b. Did you communicate with a WSIB Return-to-Work Specialist?

☐ Yes ☐ No ☐ N/A

If there are questions or concerns about the information provided in this report, please call at .

F. Signatures

Team lead regulated health professional name and signature	Regulated health professional name and signature
Date (dd/mmm/yyyy)	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.

Claim number

Last name	First name

G. Abilities and restrictions for return-to-work planning

Abilities

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100-200 metres
- ☐ Other (specify):

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15-30 minutes
- ☐ Other (specify):

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (specify):

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5-10 steps
- ☐ Other (specify):

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Limited – 0-5kg
- ☐ Light – 5-10kg
- ☐ Medium – 10-20kg
- ☐ Heavy >20kg
- ☐ Other (specify):

Lifting waist to shoulder:
- ☐ Full abilities
- ☐ Limited – 0-5kg
- ☐ Light – 5-10kg
- ☐ Medium – 10-20kg
- ☐ Heavy >20kg
- ☐ Other (specify):

Lifting above shoulder:
- ☐ Full abilities
- ☐ Limited – 0-5kg
- ☐ Light – 5-10kg
- ☐ Medium – 10-20kg
- ☐ Heavy >20kg
- ☐ Other (specify):

Pushing/pulling:
- ☐ Full abilities
- ☐ Limited – 0-5kg
- ☐ Light – 5-10kg
- ☐ Medium – 10-20kg
- ☐ Heavy >20kg
- ☐ Other (specify):

Ladder climbing:
- ☐ Full abilities
- ☐ 1-3 steps
- ☐ 4-6 steps
- ☐ Other (specify):

Ability to drive a car:
- ☐ Yes
- ☐ No – please explain:

Ability to use public transit:
- ☐ Yes
- ☐ No – please explain:

Restrictions

☐ None

☐ **Bending/twisting repetitive movement of** (please specify)**:**

Frequency: ☐ Occasional (1-33%) ☐ Frequent (34-66%) ☐ Constant (67-100%)

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Claim number

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G. Abilities and restrictions for return-to-work planning (continued)

Restrictions

☐ **Use of hand(s):**

Left		Right
☐	Gripping	☐
☐	Pinching	☐
☐	Other (please specify):	☐

Frequency: ☐ Occasional (1-33%) ☐ Frequent (34-66%) ☐ Constant (67-100%)

☐ **Operating motorized equipment** (e.g., forklift)**:**

☐ **Chemical exposure to:**	☐ **Environmental exposure to** (e.g., heat, cold, noise or scents)**:**	☐ **Potential side effects from medications (please specify):** **Note:** do not include the name of medications.	☐ **Exposure to vibration:** ☐ Whole body ☐ Hand/arm

Additional comments on abilities and restrictions:

Estimated time frame for above abilities and restrictions:

Summarize changes in functional abilities since initial assessment:

H. Signatures

Team lead regulated health professional name and signature	Date (dd/mmm/yyyy)

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