print reset save

wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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

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

Physiotherapy Assessment Report

Claim Number (If known)

start >

Please complete in full using black ink.
Incomplete or illegible reports will not be paid.

Patient Information

Last Name	First Name	Initials

Address	City	Date of Birth (dd mmm yyyy)

Province	Postal Code	Telephone	Sex
			☐ M ☐ F

Employer Information

Employer Name

Address	City	Province	Postal Code

Telephone	FAX	Date of Accident (dd mmm yyyy)	

1	Date of Initial Assessment (dd mmm yyyy)	Name of Referring Health Professional
2	Patient's History of Injury	
3	Physical Findings	
4	Working Diagnosis	
5	Is Treatment Required? ☐ yes ☐ no	If **yes**, describe the goals for treatment and approximate duration/frequency of treatment
6	Treatment Program Proposed	Can the patient work while participating in treatment? ☐ yes ☐ no
7	Are there any physical restrictions that should be observed? ☐ yes ☐ no	If **yes**, what are they?
8	Complete recovery expected? ☐ yes ☐ no	If **yes**, approximately when?
9	Describe any factors (including pre-existing or underlying conditions) which may delay recovery.	

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

Service Code	**P970**
WSIB Provider ID.	
▼ Complete these fields if HST is applicable to this form ▼	
HST Registration Number	Service Code **ONHST** / HST Amount Billed $
Service Date (dd mmm yyyy)	
Your Invoice No.	

Type your name and upload, or print and sign before returning to WSIB.

0856C (04/12)

(Français au verso)

print reset save