Musculoskeletal (MSK) program of care: Mid-point report

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

Claim number

Injury to: ☐ Single MSK zone ☐ Multiple MSK zones (approval required)

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)
This report must be completed at the end of block 1. Entitlement must be confirmed to proceed to block 2.		
Current employment status: ☐ At work ☐ Off work	Number of sessions provided in block 1:	

B. Regulated health professional information			
Name	Profession		WSIB provider ID
Facility name	Telephone		Date of report (dd/mm/yyyy)
Address (number, street, unit/suite)			
City/town	Province	Postal code	Date of last treatment session (dd/mm/yyyy)

C. Progress to date

1. Response to treatment to date: ☐ Fully recovered (from workplace injury) ☐ Significant improvement ☐ Minimal improvement ☐ No improvement ☐ Worsening

Provide details:

D. Additional referral and recovery recommendations

1. Are you recommending any additional referral for assessment or intervention? Where determined appropriate for the occupational injury, the WSIB will assist in facilitating access.

☐ Yes – provide details below ☐ No

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

Ce document est disponible en français sous le titre: *Rapport de mi-parcours* (10636B; 2023).

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Last name	First name	Date of birth (dd/mm/yyyy)

D. Additional referral and recovery recommendations (continued)

2. Are there any factors that may delay the injured 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/social withdrawal
- ☐ 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 (specify):

3. Indicate the recovery and return-to-work goals for block 2:

4. Have you discussed returning to work with the injured person?

☐ Yes ☐ No

Outline discussion:

Regulated health professional signature	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.

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Claim number

Last name	First name	Date of birth (dd/mm/yyyy)

Regulated health professional last name	Regulated health professional first name	Date of this assessment (dd/mm/yyyy)

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

Last name	First name	Date of birth (dd/mm/yyyy)

Regulated health professional last name	Regulated health professional first name	Date of this assessment (dd/mm/yyyy)

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)**:**

☐ **Work at heights:**

☐ **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:

Regulated health professional signature	Date (dd/mmm/yyyy)

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