Interdisciplinary team program of care: Initial assessment report

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

Claim number

You must receive approval from us before delivering this program.

A. Injured person information			
Last name		First name	
Address (number, street, unit/suite)			
City/town	Province	Postal code	Telephone
Date of birth (dd/mm/yyyy)		Date of injury (dd/mm/yyyy)	
Area(s) being treated			
Job title/occupation		Current employment status: ☐ At work ☐ Off work	

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 this assessment (dd/mm/yyyy)	

C. Clinical information
1. History of injury (provide details regarding mechanism of injury):
2. Investigations, consultations and treatment to date (including surgery):
3. Describe relevant past medical history (e.g., previous occupational and non-occupational diagnoses, conditions, surgeries):

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 d'évaluation initiale,* 10708B (11/23).

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4. Describe the person's current symptoms:

5. Describe any impact on functional status (social, occupational, personal):

6. Identify and describe any psychosocial stressors impacting recovery, if present.

7. Summary of physical assessment findings (include examination findings for all areas of injury):

Testing	**Findings and details (include relevant negative findings)**
Hand dominance	☐ Right-handed ☐ Left-handed ☐ Ambidextrous
Observation and palpation (e.g., posture, gait, immobilization status)	

Area of body/joint movement	Active range of motion		Passive range of motion		Strength testing	
	Right	Left	Right	Left	Right	Left

Limiting factor(s)/comments:

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Neurological testing (e.g., sensory, motor reflexes, neurodynamic testing):
Relevant orthopedic/special testing:
Other (specify):

D. Outcome measures

Complete at least one functional outcome measure that relates to the person's area(s) of injury. Repeat the same outcome measure(s) throughout the treatment period.

	Score
☐ Neck Disability Index (NDI) **Level of disability**: 0 to 4 (0-8%) = none; 5 to 14 (10-28%) = mild; 15 to 24 (30-48%) = moderate; 25 to 34 (50-64%) = severe; above 34 (70-100%) = complete disability	%
☐ Oswestry Low Back Pain Disability Questionnaire (ODI 2.1a version) **Level of disability**: 0-20% = minimal; 21-40% = moderate; 41-60% = severe disability; 61-80% = crippled; 81-100% = bed bound/exaggerating symptoms	%
☐ QuickDASH Disability/Symptom	/100
☐ QuickDASH Work Module The higher the score, the greater the disability	/100
☐ Lower Extremity Functional Scale (LEFS) The lower the score, the greater the disability	/80
☐ World Health Organization Disability Assessment Schedule (WHODAS 2.0-12 item version) The higher the score, the greater the disability	/48

Where clinically indicated, complete the applicable anxiety/mood/pain measure(s). Repeat as needed throughout the treatment period.

☐ Generalized Anxiety Disorder -7 (GAD-7) **Level of anxiety symptoms**: 0 to 9 = none to mild; 10 to 14 = moderate; 15 to 21 = severe	/21
☐ Patient Health Questionnaire-9 (PHQ-9) **Level of depressive symptoms**: 0 to 4 = none; 5 to 9 = mild; 10 to 14 = moderate; 20 to 27 = severe	/27
☐ Pain Self-Efficacy Questionnaire (PSEQ) Lower scores indicate lower self-efficacy and lower levels of confidence in dealing with pain	/60

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Comments (provide interpretation, key findings, etc. from outcome measures used):

E. Diagnosis and prognosis

1. Provide occupational diagnosis(es) and prognosis(es):

Diagnosis(es)	Prognosis e.g., expecting full functional recovery; expecting partial recovery; not expecting further recovery	Expected timeframe and rationale Support with clinical findings and recovery barriers

2. 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 (specify):

Last name	First name

F. Treatment plan and additional referral recommendations

1. Indicate recovery and return-to-work goals and treatment interventions. Treatment goals should be specific, measurable, achievable, relevant and time bound, where possible.

Treatment goals	Planned interventions
1)	
2)	
3)	
4)	
5)	

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

3. 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:

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

G. 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.

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H. 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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H. 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:

I. Signatures

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

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