Interdisciplinary team program of care: Mid-point report

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*, 10710B (11/23).

Claim number

Last name	First name

D. 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):

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 .

E. 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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Claim number

Last name	First name

F. 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

F. 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:

G. Signatures

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

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