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wsib cspaat ONTARIO

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

or

Fax to:
416-344-4684
or 1-888-313-7373

Program of Care for Mild Traumatic Brain Injury Care & Outcomes Summary

Please PRINT in black ink.

Start >

Claim Number

A. Patient Information Section

Last Name | First Name | Init.

Date of Birth (dd mm yyyy) | Date of Accident (dd mm yyyy)

This report must be submitted WHENEVER the patient is discharged

A. Patient completed Program of Care fully? ☐ Yes **OR**

B. Patient did not return/self-discharged from Program of Care? ☐ Yes

Specify date of last visit (dd mm yyyy)

C. Is this report within 3 months of accident ☐ Yes **OR**

D. More than 3 months, but less than 1 year ☐ Yes

B. Health Professional Billing Information

☐ Chiropractor ☐ Massage Therapist ☐ Occupational Therapist ☐ Physician ☐ Physiotherapist

☐ Psychologist ☐ RN (EC) ☐ Speech-Language Pathologist ☐ Other (specify) _____

Health Professional Name (please print)

WSIB Provider ID.

Facility Name (if applicable)

Your Invoice No.

Address (no. street, apt.)

Date of Discharge (dd mm yyyy)

City/Town | Prov. | Postal Code | Telephone No.

Service Code **MTBICOS**

HST Registration No.

HST Amount Billed

C. Clinical Information

1. Summary of self-reported symptoms at discharge (check all that apply):

Comments:

☐ Attention/Concentration
☐ Depressed
☐ Dizziness/Vertigo
☐ Double Vision
☐ Fatigue
☐ Forgetfulness/Poor Memory
☐ Frustrated/Impatient
☐ Headaches
☐ Irritability/Easily Angered
☐ Light Sensitivity
☐ Nausea and/or Vomiting
☐ Noise Sensitivity
☐ Restlessness
☐ Sleep Disturbance
☐ Taking Longer To Think
☐ Other (specify):

2. Describe any changes in health status:

3. Indicate if additional treatment(s) /assessment(s) or referral(s) are required: ☐ Yes ☐ No
Indicate treatment recommended:

4. Describe patient's limitations in Activities of Daily Living (ADL):

☐ Self Care _____
☐ Hobbies _____
☐ Child Care _____
☐ Communication _____
☐ Sports/Leisure Activities _____
☐ Sleep Disturbance _____
☐ Housekeeping _____
☐ Other (specify):

5. Has the patient physically returned to pre-injury level of overall function? ☐ Yes ☐ No
If **No,** list any outstanding issues:

Patient's Last Name	First Name
Date of Birth dd mm yyyy	Date of Accident dd mm yyyy

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C. Clinical Information (continued)

6. List any recommendations to resolve these issues and progress made to address these issues.

7. Are there any complicating factors that may delay recovery? ☐ Yes ☐ No

If **Yes,** please identify:

- ☐ Believes hurt equals harm
- ☐ Fears/avoids activity
- ☐ Low mood/social withdrawal
- ☐ Prefers passive treatments
- ☐ Home environment concerns
- ☐ Work environment concerns
- ☐ Other (specify):

8. Are additional treatment(s) assessment(s) or referral(s) required? ☐ Yes ☐ No

If **Yes,** please indicate: _____

9. Administer and record: Rivermead Score _____/64 (Total of all scores excluding Other Difficulties)

Administer and record: RAND SF-36 Scores

- ☐ Emotional well-being ____ /100
- ☐ Pain ____ /100
- ☐ Role limitations due to emotional problems ____ /100
- ☐ Energy/fatigue ____ /100
- ☐ Physical functioning ____ /100
- ☐ Role limitations due to physical health ____ /100
- ☐ General health ____ /100
- ☐ Social function ____ /100

D. Return To Work Information

10. Has the patient returned to work? ☐ Yes ☐ No

If **No,** indicate reason(s): _____

If **Yes,** specify Date dd mm yyyy

11. How long do you anticipate before the worker can return to full and unrestricted work?

____ days

Patient's current employment status:

- ☐ Full Time OR ☐ Part Time
- ☐ Regular Work OR ☐ Modified Work
- ☐ Regular Hours OR ☐ Modified Hours

12. Describe the patient's functional limitations:

A. ☐ No Limitations

B. ☐ Limitations (please specify):

- ☐ Assembly line
- ☐ Heights
- ☐ Operating motor vehicle
- ☐ Climbing stairs/ladders
- ☐ Lifting
- ☐ Positional limitation of head and neck
- ☐ Environmental
- ☐ Operating machinery
- ☐ Standing
- ☐ Other (specify):

Comments:

13. Indicate any additional recommendations for safe and sustainable return to work:

Patient's Last Name	First Name
Date of Birth dd mm yyyy	Date of Accident dd mm yyyy

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D. Return To Work Information (continued)

14. Has the patient made contact with the employer since the injury?: ☐ Yes ☐ No

Comments:

15. Indicate type of contact you had with the employer: ☐ Verbal ☐ Written ☐ None

Where no contact has been made, please indicate reason: ☐ Could not reach ☐ Did not receive call back ☐ Contact not initiated

E. Summary of Care Delivered

Program of Care Interventions supported by evidence **16.** Mark **(X)** in appropriate box(es) for each POC intervention/treatment delivered.	**Less than 3 Months** since date of injury	**More than 3 Months** since date of injury
01 education	☐	☐
02 cognitive rehabilitation		☐
03 manual mobilization therapy		☐
Program of Care Interventions not supported by evidence **17.** Mark **(X)** in appropriate box(es) for each intervention/treatment not recommended that was delivered. 04 ☐ pharmacological interventions (Amitripelavil, DDAVP, DHE).	☐	☐
18. Mark **(X)** in appropriate box(es) for other intervention/treatment that were delivered. 05 ☐ other (specify):	☐	☐
19. Visit Summary Total number of visits attended by patient during Program Of Care:		

It is an offense to knowingly make a false or misleading statement or representation to the Workplace Safety and Insurance Board (WSIB). I hereby declare that the information being submitted is true and complete.

Health Professional's Signature	Telephone	Date dd mm yyyy
Type your name and upload, or print and sign before returning to WSIB.		

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