

Health Professional's Report (Form 8)

For

Chiropractors Physicians Physiotherapists Registered Nurses (Extended Class)

Health Professionals, please use this form when:

- Your patient states that an injury/illness is related to his or her work.
- You believe that the cause of your patient's injury/illness is due to workplace factors.

Section 37 of the *Workplace Safety and Insurance Act, 1997* provides the legal authority for health professionals, hospitals and health facilities to submit, without consent, information relating to a worker claiming benefits to the Workplace Safety and Insurance Board (WSIB).

Your promptness in completing this form is key to our ability to process and adjudicate your patient's claim. Your patient, their employer and the WSIB depend on you.

When completing this report, please **print** using **black pen**.

Your patient should complete Section A of this report. If your patient needs assistance, please help. Please submit this report even if Section A is not fully completed.

Information for completing this report can be found on **Page 4**. For more details, refer to "Guidelines for Health Professionals – Completing WSIB Forms".

Please separate and send **Pages 2 and 3** to the Workplace Safety and Insurance Board:

By Fax to:

416-344-4684 or 1-888-313-7373

Or by Mail to:

Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

wsib
ONTARIO

www.wsib.on.ca

A. Patient and Employer Information (Patient May Complete Section A)

Last Name		First Name		Init.	
Address (no., street, apt.)					
City/Town			Prov.	Postal Code	Telephone
Social Insurance No.	Date of Birth	dd	mm	yyyy	Sex <input type="checkbox"/> M <input type="checkbox"/> F
		Language <input type="checkbox"/> Eng. <input type="checkbox"/> Fr.			
Business or Company Name					
Address (no., street, apt.)					
City/Town			Prov.	Postal Code	Telephone
Is this the first visit to a health professional for this injury? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown					
The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the <i>Workplace Safety and Insurance Act</i> . The Social Insurance Number is used to register claims, identify workers and to issue income tax information statements as authorized by the <i>Income Tax Act</i> . Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.					

B. Health Professional Billing Information

<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Physician	<input type="checkbox"/> Physiotherapist	<input type="checkbox"/> Registered Nurse (Extended Class)
Health Professional Name (please print)			
Address (no. street, apt.)			
City/Town	Prov.	Postal Code	Telephone

Service Code	8	
▼ Complete these fields if HST applies to this form ▼		
HST Registration Number	Service Code	HST Amount Billed
	ONHST	\$.
WSIB Provider ID.		
Service Date	dd	mm yyyy
Your Invoice No.		

C. Incident Dates and Details Section

<p>1. What is your understanding as to how this injury/illness or re-injury occurred?</p> 	<p>Date of Accident/or when did the symptoms start?</p> <p>dd mm yyyy</p>
<p>2. For this injury, are you this patient's primary Health Professional? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	
<p>Location of this assessment <input type="checkbox"/> Office <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Workplace <input type="checkbox"/> Walk-in Clinic <input type="checkbox"/> Other</p>	

D. Clinical Information Section

<p>1. Area of Injury (Body Part) - (Please check all that apply)</p>										
<input type="checkbox"/> Brain	<input type="checkbox"/> Ears	<input type="checkbox"/> Upper back	Left	Right	Left	Right	Left	Right	Left	Right
<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Lower back	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eyes	<input type="checkbox"/> Chest	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other:										
<p>2. Description of Injury - (Please check all that apply)</p>			<p>Musculoskeletal</p>			<p>Exposure/Other</p>				
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Disc Herniation	<input type="checkbox"/> Repetitive Strain Injury	<input type="checkbox"/> Asthma	<input type="checkbox"/> Infectious Disease						
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Needle Stick						
<input type="checkbox"/> Avulsion	<input type="checkbox"/> Epicondylitis	<input type="checkbox"/> Spinal Cord Injury	<input type="checkbox"/> Fumes - Inhalation	<input type="checkbox"/> Poisoning/Toxic Effects						
<input type="checkbox"/> Bite	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Psychological						
<input type="checkbox"/> Burn	<input type="checkbox"/> Ganglion	<input type="checkbox"/> Tendonitis/Tenosynovitis								
<input type="checkbox"/> Contusion/Hematoma	<input type="checkbox"/> Hernia									
<input type="checkbox"/> Crush Injury	<input type="checkbox"/> Laceration									
<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/> Puncture	<input type="checkbox"/> Other								

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

D. Clinical Information Section (continued)

3. Patient's Present Complaints - subjective complaints (Please check all that apply)

Pain
 Paresthesia
 Stiffness
 Swelling
 Weakness
 Other _____

Additional details (if applicable)

4. Physical Examination - objective findings (Please check all that apply)

Bruising
 Crepitation
 Joint Dysfunction
 Laceration
 Tenderness
 Other _____

Burns
 Deformity
 Joint Effusion
 Lump/Swelling
 Wasting

Additional details (if applicable)

5. Are there abnormal signs for any of the following? (Please check all that apply)

Active ROM
 Passive ROM
 Gait
 Strength
 Reflexes
 Sensation
 Other _____

If so please describe:

6. Are you aware of any pre-existing or other conditions/factors that may delay recovery? yes no

Additional details (if applicable)

7. Diagnosis/Working Diagnosis

E. Treatment Plan and Return to Work Information

1. Provide your treatment and management plan for this patient. Outline goals, duration, frequency, medication(s) prescribed (including any adverse effects) and any assistive devices (crutches, orthotics, etc.,) if required.

2. Investigations & Referrals:

None
 Labs
 X-rays
 CT Scan
 MRI
 EMG/NCS
 Other _____

Family GP
 Chiropractor
 Massage Therapist
 Occupational Health Centre

Specialist
 Physiotherapist
 Occupational Therapist
 Other: _____

Name of Referral or Facility (if known)	Telephone	Appointment Date
dd	mm	yyyy

3. Please indicate the patient's status and task limitations in relation to the diagnosis (please see Page 4 for special instructions)

<p>A. <input type="checkbox"/> No Limitations</p> <p>B. <input type="checkbox"/> Limitations (as specified)</p> <p>C. <input type="checkbox"/> Other (Explanation Required)</p>	<div style="border-left: 2px solid black; border-right: 2px solid black; height: 40px; margin: 0 auto;"></div>	<p> <input type="checkbox"/> Standing <input type="checkbox"/> Climbing Stairs/Ladders <input type="checkbox"/> Sitting <input type="checkbox"/> Use of Upper Extremities <input type="checkbox"/> Lifting <input type="checkbox"/> Operating Heavy Equipment <input type="checkbox"/> Bending/Twisting <input type="checkbox"/> Limitations Due To Environmental Conditions <input type="checkbox"/> Kneeling <input type="checkbox"/> Personal Protective Equipment </p>	<p> <input type="checkbox"/> Use of Public Transportation <input type="checkbox"/> Operation of a Motor Vehicle <input type="checkbox"/> Medication <input type="checkbox"/> Other _____ </p>
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Explanation/Additional details:

<p>4. From the date of this assessment, the above status(es) will apply for approximately:</p> <p> <input type="checkbox"/> 1 to 2 days; <input type="checkbox"/> 3 to 7 days; <input type="checkbox"/> 8 to 14 days; <input type="checkbox"/> 14+ days </p>	<p>5. Have you discussed Return To Work and these task limitations as part of your treatment with your patient? <input type="checkbox"/> yes <input type="checkbox"/> no</p>
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6. Follow-up Appointment None Required;
 Next Day;
 2 to 3 days;
 1 week;
 2 weeks

It is an offence to knowingly make a false or misleading statement or representation to the WSIB. I hereby declare that the information being submitted is true and complete.

Health Professional's Signature	Date
	dd mm yyyy

Health Professional's Report (Form 8) Guidelines for Completion

The following information provides some assistance in completing the Form 8. For additional details please see "Guidelines for Health Professionals – Completing WSIB Forms".

Section A - Patient and Employer Information (Patient to complete this section)

- The information in this section helps to register and administer the patient's claim. It also ensures that the Health Professional's report is sent to the correct claim file. If a patient is unable to complete this section, the Health Professional can assist.
- The patient's personal information is collected under the authority of *The Workplace Safety and Insurance Act* and is used to administer the claim. For more information contact the WSIB Privacy Office toll-free at 1-800-387-5540, ext. 5323 or (416) 344-5323.
- If the patient is unable to supply the SIN number, or other information, the form should still be completed and submitted to the WSIB.

Sections B, C, D and E (to be completed by the Health Professional)

Section D – Clinical Information Section

Please check (✓) all that apply. Include all relevant clinical and/or objective findings or symptoms. Space has been provided for any additional findings/symptoms not listed, or for any other details.

Section E – Treatment Plan & Return to Work Information

Special Instructions:

You are invited to discuss case assessment options with a WSIB medical consultant to assist this worker with a successful return to work. Please do not hesitate to contact us at 416-344-1000 or toll-free 1-800-387-0750.

If the worker or employer has given you a WSIB Functional Abilities Form (FAF) to complete at the same time as you are filling out the Form 8, you do not need to answer Questions E3 - E4 - E5.

If you are indicating the patient is unable to return to work at this time, please provide an explanation in the space provided with Question E3.

- "Please indicate the patient's status and task limitations in relation to the diagnosis." Always complete this question and check (✓) all that apply:
 - A. "No limitations": Patient is able to return to work now; no task limitations needed.
 - B. "Specified Limitations (Please Specify)": Please check all limitations that apply (e.g. standing, sitting, lifting). If you wish to provide further details, please use the space provided.
 - C. "Other (Explanation Required)": If the patient is unable to return to work in any capacity, the WSIB needs to know why in order to make a determination on entitlement to benefits. Use the space provided to give us this information.
- Please note: You can check more than one status or time period if needed and give an explanation in the space provided e.g., - No return to work for 1 - 2 days, then a return to work with a lifting limitation for 3 - 7 days.
- "From the date of this assessment, the above status(es) will apply for approximately:" Check (✓) the time period. Please note that for anything beyond 14 days, the WSIB will request a Progress Report.

This Health Professionals Report (Form 8) is not intended to replace the

WSIB - Functional Abilities Form (FAF) - form 2647A.