wsib ONTARIO

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

Or Fax To:
416-344-4684
OR 1-888-313-7373

NIHL Rehabilitation Follow-up Form

Claim Number (If known)

To avoid delays, please complete in full printing in black ink.

A. Patient & Employer Information Section (Patient to Complete this Section)

Last Name | First Name | Init.

Address (no. street, apt.)

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

Date of Birth (dd mm yy) | Date of Accident (dd mm yy) | Date of Assessment (dd mm yy) | Sex ☐ M ☐ F

If return to work is considered, has the employer been contacted? ☐ yes ☐ no

Employer Name | Supervisor/Contact Name

Address (no. street, apt.)

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

B. Health Professional/Service Provider Billing Information

Health Professional/Service Provider Name (please print)

Facility

Address (no. street, apt.)

City/Town

Prov. | Postal Code | Telephone No. | Extension | Fax No.

Service Code **NIHLCOS**

▼ Complete these fields if˙<GHis applicable to this form ▼

HST Registration No.	Service Code	HST Amount Billed
	ONHST	**$.**

WSIB Provider ID.

Your Invoice No.

C. Outcome Measurement (COSI™- Client Oriented Scale of Improvement)

COSI™ ☐ yes **(please attach)** ☐ no **(please explain)**

If **no**, explain

A.	Degree of change COSI™ column totals	Worse	No Difference	Slightly Better	Better	Much Better	=
B.	Final ability COSI™ column totals	Hardly Ever	Occasionally	Half of the Time	Most of the Time	Almost Always	=

Total # Category Identified A = B

D. Assessment of Barriers to Utilization of Hearing Aid

Do any of the following barriers exist?

☐ Physical ☐ Psychological ☐ Education

Please explain any barriers and treatment strategy

Signature of Health Professional/Service Provider | Date (dd mm yy)