Interdisciplinary team program of care: Supplementary 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)

Submit this form when the person has completed the interdisciplinary team program of care or when discharged.

☐ Injured person has completed this program of care ☐ Injured person did not return/self-discharged

Area(s) being treated:	Current employment status: ☐ At work ☐ Off work
Supplementary block number:	Number of sessions provided in supplementary block:

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. Clinical information

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 complémentaire,* 10714B (11/23)

Last name	First name

C. Clinical information (continued)

3. Describe the person's current symptoms:

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

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

6. 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)	

	Initial assessment						**Current assessment**					
Area of body/joint movement	Active range of motion		Passive range of motion		Strength testing		Active range of motion		Passive range of motion		Strength testing	
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left

Limiting factor(s)/comments:

Neurological testing (e.g., sensory, motor reflexes, neurodynamic testing):

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C. Clinical information (continued)

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.

	Initial assessment score	Current 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	____ /100
QuickDASH Work Module The higher the score, the greater the disability	____ /100	____ /100
☐ Lower Extremity Functional Scale (LEFS) The lower the score, the greater the disability	____ /80	____ /80
☐ World Health Organization Disability Assessment Schedule (WHODAS 2.0-12 item version) The higher the score, the greater the disability	____ /48	____ /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	____ /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	____ /27
☐ Pain Self-Efficacy Questionnaire (PSEQ) Lower scores indicate lower self-efficacy and lower levels of confidence in dealing with pain	____ /60	____ /60

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

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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 (please specify):

F. Additional referral and recovery recommendations

1. 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

2. Are you recommending a supplementary block of treatment?

☐ Yes - please call us for pre-approval ☐ No - no further treatment needed

If **yes**, indicate the rationale for additional treatment and goals:

Estimated frequency of treatment: _____ times per week

Estimated duration of treatment: _____ weeks | Requested supplementary block start date: _____

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F. Additional referral and recovery recommendations (continued)

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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Last name	First name

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 abilities and restrictions:

Summarize changes in functional abilities since previous report:

I. Signature

Team lead regulated health professional name and signature	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.