

## Interdisciplinary team program of care: Supplementary report – work hardening Submit this form and supporting documents at <a href="wsib.ca/submit">wsib.ca/submit</a>.

Claim	number	

A. Injured person information								
Last name		First name						
Date of birth (dd/mm/yyyy)	Date of injury (d	d/mm/yyyy)	Da	ate of in	itial assess	ment (dd/mm/yyyy)		
Submit this form when the person has	completed the	interdisciplinary	team prog	ram of	care or wh	nen discharged.		
Injured person has completed this p	ogram of care	Injured p	erson did n	ot retur	n/self-disch	narged		
Area(s) being treated:		Current emp	oloyment sta	atus:				
		At work			Off wor	rk		
Supplementary block number:		Number of s	sessions pr	ovided	in supplem	entary block:		
B. Regulated health professional information	on							
Team lead name and profession		Other team me	ember(s) na	ame an	d professio	n		
Facility name		Telephone			WSIB prov	vider ID		
Address (number, street, unit/suite)	City/town			Provin	ce	Postal code		
Date of report (dd/mm/yyyy)		Date of last tre	Date of last treatment session (dd/mm/yyyy)					
C. Clinical information								
What treatment interventions have you	delivered?							
,								
2. Overall, response to treatment to date:								
Fully recovered (from workplace inju Minimal improvement		icant improvemen provement				Moderate improvement Worsening		
Provide details on treatment goals and pro	ogress:							

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 – Conditionnement au travail, 10715B (11/23)

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Last name					First	First name						
C. Clinical information (con	tinued)											
3. Describe the person's co		mptoms	:									
4. Describe any impact on	function	al status	s (social,	occupat	ional, pe	rsonal):						
<ul><li>5. Identify and describe an</li><li>6. Summary of physical as</li></ul>								as of ini	urv):			
Testing			-						tive find	ings)		
Hand dominance		Right-	handed				nanded				dextrous	
Observation and palpation (e.g., posture, gait, immobilization status)												
		lr	nitial ass	sessmer	nt			Cı	ırrent as	sessme	ent	
Area of body/joint movement	Active of me		Passive of me			Strength Active range testing of motion		Passive range of motion		Strength testing		
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left
Limiting factor(s)/comment  Neurological testing (e.g.,		motor re	eflexes, r	neurodyr	namic tes	sting):						

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Last name	First name		
C. Clinical information (continued)			
Relevant orthopedic/special testing:			
Other (specify):			
D. Outcome measures			
Complete at least one functional outcome measure that relates measure(s) throughout the treatment period.	s to the person's area(s) of injury.	Repeat the san	ne outcome
		Initial assessment score	Current score
Neck Disability Index (NDI)			
<b>Level of disability:</b> 0 to 4 (0-8%) = none; 5 to 14 (10-28%) = moderate; 25 to 34 (50-64%) = severe; above 34 (70-100%)		%	%
Oswestry Low Back Pain Disability Questionnaire (ODI 2.1	a version)		
<b>Level of disability:</b> 0-20% = minimal; 21-40% = moderate; 4 61-80% = crippled; 81-100% = bed bound/exaggerating symplems.		%	%
QuickDASH Disability/Symptom		/100	/100
QuickDASH Work Module		/100	/100
The higher the score, the greater the disability			
Lower Extremity Functional Scale (LEFS)		/90	/90
The lower the score, the greater the disability		/80	/80
World Health Organization Disability Assessment Schedule (WHODAS 2.0-12 item version)	9	/48	/48
The higher the score, the greater the disability			
Where clinically indicated, complete the applicable anxiety/m treatment period.	nood/pain measure(s). Repeat as	needed through	hout the
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)			
<b>Level of depressive symptoms:</b> 0 to 4 = none; 5 to 9 = mile 20 to 27 = severe	l; 10 to 14 = moderate;	/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 outcor	ne measures used):		

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Last name		Fir	First name				
E. Diagnosis and progno	sis						
	diagnosis(es) and progn	osis(es):					
Diagnosis(es)		Prognosis		Expected timefrai	me and rationale		
		g full functional recry; not expecting f		Support with clini recovery			
2. Are there any factors If <b>yes</b> , indicate below: Fear/avoidance of	that may delay the personactivity Doe	on's recovery and s not feel ready to		k?	Yes No		
Co-morbid condition Limited support Believes hurt equat Low mood Other (please specify):	ns "Med Wor Is harm Diffid	dium to heavy" job king conditions ar culty transitioning	duties				
F. Occupational status							
Current work hours:	At work - full hours	At work - partial	hours	Off work			
Current work duties:	Pre-injury job	Pre-injury job ad	ccommodated	Alternate work	Off work		
Is the person managing was If <b>no</b> , provide details be	vith their current work dutie low:	s? Yes	No	N/A			
Have you reviewed a mee Yes No If <b>no</b> , provide details be	eting memo/plan from a W	SIB Return-to-Wor	k Specialist to deve	lop the work hardening	protocol?		

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Last name	First name

G. Work hardening/functional testing	ng		
Essential job duties of concern and relevant physical demands (e.g., force, posture, frequency, distance)	· •	Abilities - supplementary block number	Observations/comments (document relevant findings)
E.g., Load/unload orders: Front- lifting up to 20 lbs from floor to shoulder level on an occasional basis	E.g., Front-lifting up to 10 lbs from waist to shoulder level on occasional basis	E.g., Able to front-lift up to 20 lbs from floor to shoulder level on occasional basis	E.g., Achieved and able to complete relevant physical demands for this duty
1)			
2)			
3)			
4)			
5)			

Occasional (1-33% of the workday); Frequent (34-66% of the workday); Constant (67-100% of the workday)

H. A	dditional	referral	and	recovery	y recomr	nendati	ons
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1. Are you recommending any addi	tional referral(s) for assessment of	r intervention? We ca	n help the person access other
services, where appropriate.	Yes - provide details below	No	

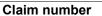
2. Are you recommending a supplementary block of treatment?

Yes - please call us for pre-approval

No - no further treatment needed

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

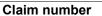
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Last name	First name				
H. Additional referral and recovery recommendations (contin	auod\				
n. Additional referral and recovery recommendations (contin	iueu)				
Estimated frequency of treatment:times per wee	ek				
Estimated duration of treatment: weeks	Requested supplementary block start date:				
<ul> <li>3a. Did you communicate with other treating health care proceed to contracted providers, orthopedic surgeon, family physically yes No N/A</li> <li>If yes, outline discussion:</li> </ul>	rofessionals (e.g., musculoskeletal program of care provider, other cian, etc.)?				
3b. Did you communicate with a WSIB Return-to-Work Spe	ecialist?				
Yes No N/A					
If there are questions or concerns about the information pr at	ovided in this report, please call				
I. Signatures					
Team lead regulated health professional name and signatu	Regulated health professional name and signature				
Date (dd/mmm/yyyy)	Date (dd/mmm/yyyy)				
Check this box if you are completing and submitting fill out your name and the date above.	this form electronically. This represents your signature. You must				

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Last name First name

	s for return-to-work planning				
Abilities					
Walking: Full abilities Up to 100 metres 100-200 metres Other (specify):	Standing: Full abili Up to 15 15-30 m Other (s	5 minutes iinutes	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):	Full abili Limited - Light – 5	– 0-5kg 5-10kg – 10-20kg •20kg	Lifting waist to shoulder: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):		
Lifting above should Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):	Full abili Limited - Light – 5	ities – 0-5kg 5-10kg – 10-20kg <sup>-</sup> 20kg	Ladder climbing: Full abilities 1-3 steps 4-6 steps Other (specify):		
Ability to drive a car Yes No – please explai	•		Ability to use public transit: Yes No – please explain:		
Restrictions Nor	ne				
Bending/twisting rep	etitive movement of (please s	specify):			
Frequency: Oc	casional (1-33%) Frequ	ent (34-66%)	Constant (67-100%)		

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Last name			First name				
J. Abilities and restrictions for	or return-to-work pla	nning (continເ	ıed)				
Restrictions							
Use of hand(s):							
Left	Righ	nt					
Grij	pping						
Pin	ching						
Other (plea	ase specify):						
Frequency: Occa	sional (1-33%)	Frequent (	34-66%)	Constant (67-100%)	)		
Operating motorized ed	quipment (e.g., fork	lift):					
Chemical exposure to:	Environmental	exposure	Potential	side effects from	Exposure to vibration:		
	to (e.g., heat, co	old, noise	medication	ons (please specify):	Whole body		
	or scents):				Hand/arm		
				i idild/diffi			
			Note: do not medications	Note: do not include the name of			
Additional comments on a	hilities and restric	tions:	medications				
Additional comments on t		tions.					
Estimated time frame for a	abilities and restric	tions:					
Summarize changes in fu	nctional abilities si	nce previous	report:				
odininanze changes in rui		nce previous	o report.				
K. Signature         Team lead regulated health professional name and signature       Date (dd/mmm/yyyy)							
ream lead regulated nealth	professional name a	and signature			Date (dd/mmm/yyyy)		
Check this box if you	are completing and	submitting thi	s form electro	nically This represents	vour signature. Vou must		

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fill out your name and the date above.