

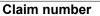
## Musculoskeletal (MSK) program of care: Mid-point report

Claim number

Submit this form and supporting documents at wsib.ca/submit.

Injury to: Single MSK zone Multiple MSK zones (approval required)					
	First name				
Date of injury (dd/mm/yyyy)		Date of initial assessment (dd/mm/yyyy)			
e end of block 1.		<u> </u>			
	Number of ses	ssions provided in b	lock 1:		
nation					
	ion		WSIB provider ID		
Telephone		Date of re	Date of report (dd/mm/yyyy)		
Province	Postal code	Date of last treatme	ast treatment session (dd/mm/yyyy)		
Fully recovere	d (from workplace inj	ury) Sig	nificant improvement		
Minimal impro	vement No imp	provement Wo	rsening		
mmendations					
<b>1.</b> Are you recommending any additional referral for assessment or intervention? Where determined appropriate for the occupational injury, the WSIB will assist in facilitating access.					
No No					
	Province  Fully recovere Minimal impro  mmendations  all referral for assest in facilitating access to the content of the cont	Province Postal code  Fully recovered (from workplace inj Minimal improvement No important No important in facilitating access.	Province Postal code Date of last treatment must be confirmed to province Postal code Date of last treatment must be confirmed to province Postal code Date of last treatment must be confirmed to province Postal code Date of last treatment must be confirmed to province Province Date of last treatment must be confirmed to province Province Date of last treatment must be confirmed to province Province Date of last treatment must be confirmed to province Province Date of last treatment must be confirmed to province Province Date of last treatment must be confirmed to province Date of last treatment must be confirmed to province Date of last treatment must be confirmed to province Date of last treatment province Date of last treatment must be confirmed to province Date		

Contact <u>accessibility@wsib.on.ca</u> if you require this communication in an alternative format. Ce document est disponible en français sous le titre: *Rapport de mi-parcours* (10636B; 2023).





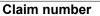
Last name	First name	Date of birth (dd/mm/yyyy)					
D. Addistance I and an addistance and asset							
D. Additional referral and recovery recommendations (continued)							
2. Are there any factors that may delay the injured person's recovery and their return-to-work?							
Yes No							
If <b>yes</b> , indicate below:							
Fear/avoidance of activity	Does not feel ready to return to wo	·k					
Co-morbid conditions	"Medium to heavy" job duties						
Limited support	Working conditions and/or shift work						
Believes hurt equals harm	Difficulty transitioning from modified to pre-injury duties						
Low mood/social withdrawal	Does not feel current work duties are suitable						
Other (specify):							
3. Indicate the recovery and return-to-work goal	s for block 2:						
4. Have you discussed returning to work with th	e injured person?						
Yes No							
Outline discussion:							
Regulated health professional signature		Date (dd/mmm/yyyy)					
regulated fleath professional signature	,	Jate (dd/ffiffiffi/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.							
iiii dat ydai fiaifie and the date above.							

10636A Page 2 of 4



Last name	First name	t name		Date of birth (dd/mm/yyyy)	
Regulated health professional last name	Regulated health pr	professional first name Date of this asse		is assessment (dd/mm/yyyy)	
Abilities and restrictions for return-to-work	planning				
Abilities	Ctandina.		Cittina		
Walking:	Standing: Full abilities		Sitting:	Full abilities	
Full abilities					
Up to 100 metres	Up to 15 minutes		Up to 30 minutes		
100-200 metres	15-30 minutes		30 minutes-1 hour		
Other (specify):	Other (specify)	Other (specify):		Other (specify):	
Stair climbing:	Lifting from floor to waist: Li		_	vaist to shoulder:	
Full abilities	Full abilities		Full abilities		
Up to 5 steps	Limited – 0-5kg	9		d – 0-5kg	
5-10 steps	Light – 5-10kg		Light – 5-10kg		
Other (specify):	Medium – 10-2	20kg	Medium – 10-20kg		
	Heavy >20kg		•	<sup>,</sup> >20kg	
	Other (specify)	:	Other	(specify):	
Lifting above shoulder:	Pushing/pulling:		Ladder o	climbing:	
Full abilities	Full abilities		Full at	pilities	
Limited – 0-5kg	Limited – 0-5kg		1-3 ste	eps	
Light – 5-10kg	Light – 5-10kg		4-6 ste	eps	
Medium – 10-20kg	Medium – 10-20kg		Other	(specify):	
Heavy >20kg	Heavy >20kg				
Other (specify):	Other (specify)	:			
Ability to drive a car:		Ability to use public transit:			
Yes		Yes			
No – please explain:		No – please explain:			
Restrictions None					
	ment of (please spec	cify):			
Bending/twisting repetitive move	ment of (please spec	cify):			
Frequency: Occasional (1-33%)	) Frequent (34	1-66%) Consta	ant (67-100	%)	

10636A Page 3 of 4





Last name	First name			Date of birth (dd/mm/yyyy)		
Regulated health professional last name F	Regulated health professional first name Date of t		Date of th	is assessment (dd/mm/yyyy)		
Abilities and restrictions for return-to-work planning (continued)						
Restrictions						
Use of hand(s):						
	Right					
Gripping						
Pinching						
Other (please specify):						
Frequency: Occasional (1-33%)	Frequent (34-66%)	Consta	int (67-100	%)		
Operating motorized equipment (e.	g., torkiitt):					
Work at heights: Exposure to v						
		W	hole body	Hand/arm		
Additional comments on abilities and res						
Estimated time frame for above abilities a	and restrictions:					
Summarize changes in functional abilities	s since initial assessment:					
Regulated health professional signature			D	ate (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.						

10636A Page 4 of 4