wsib ONTARIO

Musculoskeletal (MSK) program of care: Care and outcomes summary

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

Claim number

Injury to: ☐ Single MSK zone ☐ Multiple MSK zones (approval required)

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)
You must submit this report upon completion of the MSK program of care or whenever the injured person is discharged.		
☐ Injured person has completed the MSK program of care	☐ Injured person did not return/self-discharged	
Current employment status: ☐ At work ☐ Off work	Number of sessions provided in block 2:	

B. Regulated health professional information			
Name	Profession	WSIB provider ID	
Facility name	Telephone	Date of report (dd/mm/yyyy)	
Address (number, street, unit/suite)			
City/town	Province	Postal code	Date of last treatment session (dd/mm/yyyy)

C. Clinical information

1. Response to treatment to date: ☐ Fully recovered (from workplace injury) ☐ Significant improvement ☐ Minimal improvement ☐ No improvement ☐ Worsening

Provide details:

2. Summary of physical assessment findings (include examination findings for all areas of injury):

Testing	Findings and details (include pertinent negative findings)
Hand dominance	☐ Right handed ☐ Left handed
Observation (e.g., posture, gait, immobilization status)	

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

Ce document est disponible en français sous le titre: *Sommaire des soins et des résultats* (10637B; 2023).

Last name	First name	Date of birth (dd/mm/yyyy)

C. Clinical information (continued)

2. Summary of physical assessment findings (include examination findings for all areas of injury):

Testing	Findings and details (include pertinent negative findings
Palpation and range of motion (ROM): (e.g., tenderness on palpation, passive ROM, active ROM, resisted ROM, etc.)	
Neurological testing: (e.g., sensory, motor reflexes, strength, neurological tests as needed)	
Relevant orthopedic/ special testing	
Other (specify)	

3. Provide occupational diagnosis(es):

4. Are there any factors that may delay the injured 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/social withdrawal
☐ 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 (specify):

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D. Outcome measures

1. Complete at least one functional outcome measure that relates to the injured person's area(s) of injury. The same outcome measure(s) should be repeated throughout the treatment period.

Functional outcome measures	Score
☐ Neck Disability Index (NDI)	%
☐ Oswestry Low Back Pain Disability Questionnaire (ODI 2.1a version)	%
☐ QuickDASH Disability/Symptom	/100
QuickDASH Work Module	/100
☐ Lower Extremity Functional Scale (LEFS)	/80
☐ World Health Organization Disability Assessment Schedule (WHODAS 2.0-12 item version)	/48

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

E. Additional referral and recovery recommendations

1. Are you recommending any additional referral for assessment or intervention? Where determined appropriate for the occupational injury, the WSIB will assist in facilitating access.

☐ Yes – provide details below ☐ No

2. Are you recommending a supplementary block of treatment?

☐ Yes – Contact a WSIB Clinical Expert ☐ No – No further treatment needed

If **yes**, indicate treatment frequency, duration and recovery and return-to-work goals:

3. Have you discussed returning to work with the injured person?

☐ Yes ☐ No

Outline discussion:

Regulated health professional 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.

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Last name	First name	Date of birth (dd/mm/yyyy)

Regulated health professional last name	Regulated health professional first name	Date of this assessment (dd/mm/yyyy)

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	Date of birth (dd/mm/yyyy)

Regulated health professional last name	Regulated health professional first name	Date of this assessment (dd/mm/yyyy)

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)**:**

☐ **Work at heights:**

☐ **Exposure to vibration:**
☐ Whole body ☐ Hand/arm

Additional comments on abilities and restrictions:

Estimated time frame for above abilities and restrictions:

Summarize changes in functional abilities since mid-point report:

Regulated health professional signature	Date (dd/mmm/yyyy)

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