

A. Injured person and employer information			
Last name	First name	Initial	
Address (number, street, unit/suite)			
City/town	Province	Postal code	Telephone
Date of birth (dd/mmm/yyyy)		Date of accident (dd/mmm/yyyy)	
Employer name		Supervisor/contact name	Telephone
Injured person's job title/occupation			Approximate length of time in current job : months years
Employment status at time of assessment:			
<p>A. <input type="checkbox"/> Full time or <input type="checkbox"/> Part time <input type="checkbox"/> Not working</p> <p>B. <input type="checkbox"/> Regular duties or <input type="checkbox"/> Modified duties</p> <p>C. <input type="checkbox"/> Regular hours or <input type="checkbox"/> Modified hours</p> <p style="text-align: center;">If working modified duties or hours, please ask the injured person how long they think it will take to return to full hours / full duties _____ days</p> <p style="text-align: right;">If not working, please ask the injured person when they expect to return to work _____ days</p>			

B. Regulated health professional information			
<input type="checkbox"/> Chiropractor <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Other (specify) _____			
Name		Date of report (dd/mmm/yyyy)	
Facility name		Date(s) of this assessment (dd/mmm/yyyy)	
Address (number, street, unit / suite)		WSIB provider ID	
City/town	Province	Service code MTBRIAF	
Postal code	Telephone	Complete these fields if HST is applicable to this form	
		HST registration number	Service code ONHST
		HST amount billed	

C. Clinical information			
1. Name regulated health professional/facility who provided mTBI/concussion diagnosis:			Date of diagnosis (dd/mmm/yyyy)
Select:	Physician	Nurse practitioner	Occupational Health Assessment Program (OHAP), mTBI physician
2. Injured person's history of injury (provide details regarding mechanism of injury/description of accident):			
Loss of consciousness:	yes	no	If yes, Minutes
Amnesia:	yes	no	
Early onset of headaches:	yes	no	

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

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C. Clinical information (continued)

3. Previous history of:

Concussion/head injury:	yes	no	If yes,	Number of mTBIs within previous 12 months
Mental health concerns or condition:	yes	no		
Substance use disorder:	yes	no		
Neurological condition(s):	yes	no		

Provide details regarding any conditions/disorders identified above. Include other relevant and/or pre-existing medical information (include prescribed medication(s), over the counter medications/supplements and substance use, including alcohol, marijuana and other recreational drugs):

4. Investigations, consultations, and treatment to date (provide details):

5. Summary of self-reported symptoms:
 Ask the injured person to comment on the three most troublesome symptoms (e.g. intensity, frequency, duration, progression, triggers, aggravating factors)

Symptom	Description
1.	
2.	
3.	

Were these symptoms present prior to the mTBI? yes no

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6. Summary of physical findings (including pertinent negative findings):

Testing	Normal exam	Findings and details
Musculoskeletal	yes no	
Neurological	yes no	
Balance	yes no	
Vestibular	yes no	
Other (specify)	yes no	

Mental status and cognition:

Functional status/exercise testing (if appropriate):

7. Rivermead Post-Concussion Symptoms Questionnaire:
 Total all scores excluding "other difficulties". The Rivermead is available at www.wsib.ca. Score: /64

Comments:

8. Working diagnosis(es):
 mTBI/concussion Other:

Comments:

9. In your assessment, did you observe/identify any complicating factors that may delay recovery? yes no

If **yes**, please identify:

<input type="checkbox"/> Believes hurt equals harm	<input type="checkbox"/> Home environment concerns
<input type="checkbox"/> Fears/avoids activity	<input type="checkbox"/> Changes in relationship dynamics
<input type="checkbox"/> Low mood/social withdrawal	<input type="checkbox"/> Work environment concerns
<input type="checkbox"/> Prefers passive treatments	<input type="checkbox"/> Other (specify):

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10. Check all affected activities of daily living:

<input type="checkbox"/> Self care	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Leisure activities/sports
<input type="checkbox"/> Meal preparation	<input type="checkbox"/> Household maintenance (e.g. outdoor maintenance, snow shovelling)	<input type="checkbox"/> Communication
<input type="checkbox"/> Shopping (groceries)	<input type="checkbox"/> Driving	<input type="checkbox"/> Computer/television use
<input type="checkbox"/> Child care/care giving		<input type="checkbox"/> Reading

Comment on affected activities of daily living (e.g., current limitations compared with abilities prior to date of injury):

D. Functional information

11. Administer and record the scores for the Patient-Specific Functional Scale (PSFS) for three to five functional activities, at least two of which are work-related. The PSFS is available at www.wsib.ca.

Functional activity	Score	Relevant physical demands / functional requirements	Clinician's assessment of current ability
E.g. Lift from floor level	3/10	Lift 30 lb box from floor level, using both hands.	Can lift 10 lb from 8" elevation to hip level.
1.	/10		
2.	/10		
3.	/10		
4.	/10		
5.	/10		
Total: Divide the total score by the number of activities (minimum three activities)		/10	

E. Abilities, limitations and accommodations for return-to-work planning

12. Provide the injured person's functional abilities, limitations, restrictions and accommodations to facilitate return to work.

Physical	Limitations	Describe recommended accommodation
Sit/stand (duration of each / frequency of change)	yes no na	
Lifting (weight/frequency, own pace or high demand)	yes no na	
Walking (distance/time)	yes no na	
Carrying	yes no na	
Other (specify):	yes no na	

Upload forms and documents related to your claim at wsib.ca/upload

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Potential mTBI symptom triggers	Limitations	Describe recommended accommodation
Computer work (duration, frequency of breaks / other tasks)	yes no na	
Visual tasks (reading, non-computer tasks)	yes no na	
Lighting (brightness, fluorescent, etc.)	yes no na	
Noise (continuous, impact, other)	yes no na	
Interaction with public	yes no na	
Interaction with co-workers	yes no na	
Other (specify):	yes no na	
Safety considerations	Limitations	Describe recommended accommodation
Work at heights	yes no na	
Driving	yes no na	
Operating machinery	yes no na	
Other (specify):	yes no na	

F. Treatment plan and additional referral recommendations
<p>13. Indicate expected treatment interventions:</p> <ul style="list-style-type: none"> Education Gradual integration of activity Progressive exercise therapy (including balance & coordination exercises), such as the Buffalo Concussion Treadmill Test Manual therapy Vestibular rehabilitation, provide objective findings from assessment, rationale for treatment and planned interventions: <p style="margin-top: 20px;">Other (specify):</p> <p style="margin-top: 20px;">Expected treatment duration and frequency</p> <p>Estimated duration of treatment : weeks</p> <p>If you anticipate more than eight weeks of treatment, please provide rationale:</p> <p style="margin-top: 20px;">Estimated frequency of treatment: times per week</p>

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Initial education		
Did the injured person appear to understand the mTBI information/education shared?	yes	no
Did you provide written education materials?	yes	no
Topics discussed:		
Concussion knowledge	Anxiety levels	
Symptom interpretation	Managing symptoms	
Recovery expectations	Other (specify):	
14. Are you recommending additional referrals?		
	yes	no
	If yes , indicate below	
<input type="checkbox"/> WSIB Community Mental Health Program (psychology)	<input type="checkbox"/> Other WSIB Specialty Programs	
<input type="checkbox"/> Psychiatry	<input type="checkbox"/> WSIB Return to Work Specialist	
<input type="checkbox"/> WSIB OHAP mTBI Assessment	<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> WSIB Neurology Specialty Program		
Reason for referral:		
15. Other comments:		
mTBI POC regulated health professional signature	Date (dd/mmm/yyyy)	