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wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail to:
200 Front Street West
Toronto ON M5V 3J1

or Fax to:
(416) 344-4684
OR 1-888-313-7373

Shoulder Program of Care Initial Assessment Report

Please PRINT in black ink.

start -->

Claim Number

A. Patient and Employer Information

Last Name | First Name | Init.

Address (no., street, apt.)

City/Town | Province | Postal Code

Telephone | Date of Birth (dd mm yyyy) | Date of Injury (dd mm yyyy) | Sex ☐ M ☐ F

Employer Name

Supervisor/Contact Name | Telephone ( )

Patient's current job title/occupation | Length of time in current job

Employment status at time of assessment

☐ Full time **OR** ☐ Part time worker ☐ Not working
☐ Regular duties **OR** ☐ Modified duties
☐ Regular hours **OR** ☐ Modified hours

Please ask the patient:
How long do you think you will be off work? ____ days

B. Clinical Informaton

Please list the name of the referring health professional (if applicable) | Date of Referral (dd mm yyyy)

Physical Findings (please specify as necessary)

☐ Weakness _____ ☐ Loss of motion _____
☐ Painful arc _____ ☐ Instability _____
☐ Other _____

Diagnosis

☐ Acromioclavicular joint sprain ☐ Bursitis ☐ Rotator cuff partial thickness tear/tendinosis
☐ Biceps tendinitis ☐ Impingement syndrome ☐ Rotator cuff tendinitis
☐ Biceps tendon tear ☐ Rotator cuff full-thickness tear ☐ Sprain/Strain
☐ Other _____

Comments: _____

Describe the patient's limitations in Activities of Daily Living (self care, sleep history, participation in leisure, sports, hobbies).

☐ Self care _____ ☐ Sports/Leisure activities _____
☐ Hobbies _____ ☐ Sleep disturbance _____
☐ Child care _____ ☐ Housekeeping _____
☐ Other _____

Comments: _____

Describe any relevant medical information (e.g. medical history, medications, medical conditions, surgeries).

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Patient's Last Name	First Name
Date of Birth dd mm yyyy	Date of Injury dd mm yyyy

Shoulder Program of Care
Initial Assessment Report

Claim Number

B. Clinical Informaton (continued)

Please check the complicating factors that may delay recovery/RTW.

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- ☐ Believes hurt equals harm
- ☐ Prefers passive treatment
- ☐ Home environment concerns
- ☐ Low mood/social withdrawal
- ☐ Fears/avoids activity
- ☐ Work environment concerns
- ☐ Other _____

Comments: _____

Administer and record scores for QuickDASH and QuickDASH Work Modules

1. QuickDASH Disability/Symptom Score ☐
2. QuickDASH Work Module Score ☐

Frequency and duration of POC visits.

_____

C. Return to Work Recommendations

Considering your assessment findings, can patient remain/return to work? ☐ Yes ☐ No

If **Yes**, specify: ☐ Regular duties ☐ Modified duties ☐ Regular hours ☐ Modified hours

If **No**, indicate expected return date: dd mm yyyy

Describe the patient's functional limitations:

- ☐ No Limitations
- ☐ Limitations as specified below
  - ☐ Carrying _____
  - ☐ Lifting _____
  - ☐ Reaching _____
  - ☐ Pushing/Pulling _____
  - ☐ Repetitive work _____
  - ☐ Other _____
  - ☐ Overhead work _____
  - ☐ Shoulder level work _____
  - ☐ Keeping extremity away from body _____

Comments:

_____

D. Health Professional Billing Information

☐ Chiropractor ☐ Physiotherapist ☐ Other _____

Health Professional's Name (please print)	Date of this assessment dd mm yyyy
Facility Name	WSIB Provider ID.
Address (no. street, apt.)	Telephone ( )
City/Town	Prov. / Postal Code

It is an offense to knowingly make a false or misleading statement or representation to the WSIB. I hereby declare that the information being submitted is true and complete.

Health Professional's Signature *Type your name and upload, or print and sign before returning to WSIB.*	Date dd mm yyyy

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