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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 Care & Outcomes Summary

Please PRINT in black ink.

start -->

Claim Number

A. Patient Information

Last Name | First Name | Init.

Date of Birth (dd mm yyyy) | Date of Injury (dd mm yyyy) | Date of discharge from POC (dd mm yyyy)

☐ Patient completed Shoulder Program of Care ☐ Patient did not return/self-discharged from Shoulder Program of Care

Specify date of last visit (dd mm yyyy)

B. Clinical Information

1. Have you identified any outstanding recovery and/or return to work issues? ☐ Yes ☐ No
If Yes, please specify:

What is your recommendation to resolve these issues? What progress has been made to address these issues?

2. Summary of physical findings and any changes in health status (e.g. medications: quantity, type, dosage)

3. **Administer and record scores for QuickDash and QuickDash Work Module at discharge**

QuickDASH Disability/Symptom Score _____

QuickDASH Work Module Score _____

Calculate change in score from Initial to Discharge

QuickDASH Disability/Symptom Score Change _____

QuickDASH Work Module Score Change _____

4. Are you recommending this patient be referred for the Shoulder Specialist Service (please explain)? ☐ Yes ☐ No

C. Return To Work Information

5. Patient's current employment status: ☐ Returned to work ☐ No return to work (please explain)

If returned to work, please describe:

A. ☐ Regular duties **OR** ☐ Modified duties

B. ☐ Regular hours **OR** ☐ Modified hours

How long do you anticipate before the worker can return to full and unrestricted work? ☐☐ days

6. Describe the patient's functional limitations:

A. ☐ No Limitations

B. ☐ Limitations as specified below

- ☐ Carrying _____
- ☐ Lifting _____
- ☐ Reaching _____
- ☐ Pushing/Pulling _____
- ☐ Repetitive work _____
- ☐ Other _____
- ☐ Overhead work _____
- ☐ Shoulder level work _____
- ☐ Keeping extremity away from body _____

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

Shoulder Program of Care
Care & Outcomes Summary

Claim Number

C. Return To Work Information (continued)

Comments (continuation of question 6):

7. Indicate type of contact you had with the employer (if **Other**, please explain) ☐ Verbal ☐ Written ☐ Other

D. Summary of Care Delivered

Indicate the total number of visits

Code	Program of Care Interventions Supported by Evidence	Check Interventions Delivered
01	Education	☐
02	Exercises	☐
03	Mobilization	☐
04	Localized Massage	☐
Code	**Program of Care Interventions Not Supported by Evidence and Not Recommended**	
05	Acupuncture	☐
06	Electromagnetic therapy	☐
07	Electrotherapy	☐
08	Laser	☐
09	Needle aspiration	☐
10	Shockwave therapy	☐

E. Health Professional Billing Information

☐ Chiropractor ☐ Physiotherapist ☐ Other

Health Professional Name (please print)	Date of Discharge dd mm yyyy
Facility Name	WSIB Provider ID.
Address (no. street, apt.)	Your Invoice No.
City/Town	Service Code **SHCOS**
	▼ Complete these fields if HST is applicable to this form ▼

Prov.	Postal Code	Telephone ( )	HST Registration No.	Service Code	HST Amount Billed
				ONHST	**$**

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	Date
Type your name and upload, or print and sign before returning to WSIB.	dd mm yyyy

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