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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 W.
Toronto ON
M5V 3J1

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

Initial Assessment Report (2610A)
Non-Surgical Fracture Episode of Care

Please PRINT in black ink.

Start > Claim Number

A. Worker & Employer Information Section

Last Name	First Name		Init.
Address (no. street, unit)			
City/Town	Prov.	Postal Code	Telephone
Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)		Sex ☐ M ☐ F
Employer Name	Telephone No.		
Worker's Current Job Title/Occupation	Length of time in current job:	years	months

Work status at time of assessment:

☐ Full time **OR** ☐ Part time
☐ Regular duties **OR** ☐ Modified duties
☐ Regular hours **OR** ☐ Modified hours

☐ Not working
Please ask the worker before assessment:
If not working, how long do you think you will be off work? _____ days

B. Health Professional Information

☐ Chiropractor ☐ Physiotherapist ☐ Other, please specify: _____ WSIB Provider ID

Health Professional Name (please print)	Facility Name		
Address (no. street, unit)	City/Town	Prov.	Postal Code
Telephone	Date of Initial Assessment (dd/mmm/yyyy)		

C. Clinical Information

1. History of injury and treatment received to date:

2. Objective clinical findings & subjective concerns:

3. Type of fracture and anatomical location:

4. Additional information (e.g. other injuries, medical history, etc.):

5. Immobilization status:
☐ Previously immobilized ☐ Currently immobilized ☐ Never immobilized

Worker's Last Name	Worker's First Name
Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)

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D. Patient Specific Functional Scale, Rehabilitation Goals & Treatment Plan

1. **Patient Specific Functional Scale (PSFS):** Administer the PSFS and record the scores for 3-5 functional activities, at least 2 of which are work-related. The PSFS is available on the WSIB website at **www.wsib.on.ca**.

   PSFS Scoring Scheme:
   0 = Unable to perform activity
   10 = Able to perform activity at same level as before injury
2. **SMART Goal Setting:** Provide a corresponding SMART goal for each functional activity listed in the PSFS. Information on SMART goal setting is available in the Non-Surgical Fracture Episode of Care (EOC) Reference Guide on the WSIB website at **www.wsib.on.ca**.
3. **Treatment Plan:** Describe the proposed treatment plan including interventions and self-management techniques that will be used to support the worker to achieve the listed SMART goals.

	Functional Activity	Score	SMART Goal	Treatment Plan
E.g.	*Lift boxes from bottom shelf to counter*	*3/10*	*The worker will be able to lift a 30lb box from floor to waist level using both hands within 6 weeks.*	*E.g. Core strengthening exercises, lifting exercises, education on proper lifting technique, home exercise program.*
1.		*/10*		
2.		*/10*		
3.		*/10*		
4.		*/10*		
5.		*/10*		
	Total: Divide the total score by the number of activities (minimum of 3 activities)	*/10*		

E. Barriers to Recovery

1. Have you identified any barriers to recovery? ☐ Yes ☐ No

If **YES**, identify:

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

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Initial Assessment Report (2610A)
Non-Surgical Fracture Episode of Care

Instructions:
1. Submit all 3 pages of the Initial Assessment Report to the WSIB
2. Provide a copy of this page to the worker to give to their employer

Claim Number

PLEASE COMPLETE THIS PAGE AND PROVIDE A COPY TO THE WORKER

Last Name	First Name	Date of Birth (dd/mmm/yyyy)
Area(s) of injury(ies)		

F. Return to Work Recommendations

1. Have you discussed return to work with the worker? ☐ Yes ☐ No

2. ☐ Worker is capable of returning to work with no restrictions
Start Date (dd/mmm/yyyy):

OR

☐ Worker is capable of returning to work with restrictions
Start Date (dd/mmm/yyyy):

OR

☐ Worker is physically unable to return to work at this time
Objective findings to support recommendation to not return to work:

Recommendations for work hours:
- ☐ Regular Hours
- ☐ Modified Hours
- ☐ Graduated Hours

3. Please indicate the worker's status and functional abilities in relation to the workplace injuries and diagnosis.
☐ Full Functional Abilities **OR**
☐ Accommodations/Restrictions required. Identify and describe required accommodations/restrictions below:

☐ Bending/Twist		☐ Push/Pull	
☐ Climb		☐ Grip	
☐ Kneel		☐ Operate Motorized Equipment	
☐ Lift		☐ Operate Heavy Equipment	
☐ Sit		☐ Use of Public Transportation	
☐ Stand		☐ Other	
☐ Walk			

Comments:

4. From the date of this assessment, the above limitations will apply for approximately:
☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 14+ days

Health Professional's Name (Please print)	Health Professional's Signature Type your name and upload, or print and sign before returning to WSIB.
Telephone	Date (dd/mmm/yyyy)

PLEASE COMPLETE THIS PAGE AND PROVIDE A COPY TO THE WORKER

By signing below I am authorizing the above noted health professional, who is treating me, to provide my employer with a copy of this page outlining my functional abilities. I understand a copy will be sent to the Workplace Safety and Insurance Board (WSIB) by my health professional and the WSIB may send a copy of this page outlining my functional abilities to my employer, if required.

Worker's Signature	Date (dd/mmm/yyyy)

Type your name and upload, or print and sign before returning to WSIB.

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