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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

Summary Report (2611A)
Non-Surgical Fracture Episode of Care

Please PRINT in black ink.

Start > Claim Number

A. Worker & Employer Information Section

Last Name	First Name	Init.

Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)

☐ Worker completed Non-Surgical Fracture Episode of Care (EOC)
☐ Worker did not return / self-discharged from Non-Surgical Fracture EOC

Work status at time of discharge:

☐ Full time **OR** ☐ Part time
☐ Regular duties **OR** ☐ Modified duties
☐ Regular hours **OR** ☐ Modified hours
☐ Not Working

Date of Last Visit (dd/mmm/yyyy)

Number of Visits

B. Health Professional Information

☐ Chiropractor ☐ Physiotherapist ☐ Other, please specify: _____

Health Professional Name (please print)

Facility Name

Address (no. street, unit)	City/Town

Province	Postal Code	Telephone

WSIB Provider ID

Your Invoice No.

Date of Discharge (dd/mmm/yyyy)

Service code (Select one)
☐ **FXEOCUOR** - Upper Body
☐ **FXEOCLOR** - Lower Body

Complete these fields if HST is applicable to this form

HST Reg No	Service Code	HST Amount billed
	ONHST	**$**

C. Clinical Information

1. Identify changes to pertinent clinical findings:

2. Has the worker returned to their pre-injury level of overall function? ☐ Yes ☐ No

If **NO**, identify the outstanding issues, the progress made to date, and your recommendation(s) to address these issues:

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

If **YES**, identify:

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

4. Are there any outstanding issues related to return to work? ☐ Yes ☐ No

If **YES**, identify the outstanding issues, the progress made to date, and your recommendation(s) to address these issues:

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

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: List the SMART goals identified at Initial Assessment and indicate whether they were achieved.

	Functional Activity	Score at Initial Assessment	Score at Discharge Assessment	List corresponding SMART goals from Initial Assessment	Was the SMART goal achieved?
E.g.	*Lift boxes from bottom shelf to counter*	*/10*	*/10*	*Lift 30 lb box from floor level, using both hands.*	☐ Yes ■ No
1.		*/10*	*/10*		☐ Yes ☐ No
2.		*/10*	*/10*		☐ Yes ☐ No
3.		*/10*	*/10*		☐ Yes ☐ No
4.		*/10*	*/10*		☐ Yes ☐ No
5.		*/10*	*/10*		☐ Yes ☐ No
Total: Divide the total score by the number of activities (minimum of 3 activities)		*/10*	*/10*		

3. Were all SMART goals achieved during the EOC? ☐ Yes ☐ No

If **NO**, provide a brief explanation of the outstanding SMART goal(s) and recommendation(s) to support the worker to achieve these goal(s):

E.g. Worker is able to lift up to 25lbs pain free but experiences pain in affected wrist with heavier weight. Worker requires further strengthening of the wrist and practice lifting up to the target weight.

4. Describe treatment interventions provided during the Non-Surgical Fracture EOC:

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Non-Surgical Fracture Episode of Care

Instructions:
1. Submit all 3 pages of the Summary 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 **Type your name and upload, or print and sign before returning to WSIB.**	Date (dd/mmm/yyyy)

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