wsib cspaat ONTARIO

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

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

Please PRINT in black ink.

print reset save

Low Back Injuries Program of Care Initial Assessment Report

Claim Number

Start >

A. Patient & Employer Information

Last Name	First Name		Init.
Address (no. street, apt.)			
City/Town	Prov. **ON**	Postal Code	Telephone
Date of Birth dd mm yyyy	Date of Injury dd mm yyyy		Sex ☐ F ☐ M
Employer Name	Supervisor/Contact Name		Telephone
Address (no. street, apt.)			
City/Town	Prov. **ON**	Postal Code	
Patient's Current Job Title/Occupation	Length of time in current job: months years		

Patient's employment status at time of assessment:

A. ☐ Full time OR ☐ Part time worker
B. ☐ Regular duties OR ☐ Modified duties
C. ☐ Regular hours OR ☐ Modified hours
D. ☐ Not working

Please ask the patient before assessment:
If not working how long do you think you will be off work?

_____ days

B. Health Professional Information

☐ Chiropractor ☐ Physiotherapist ☐ Other _____

Health Professional Name (please print)			WSIB Provider ID.
Facility Name			
Address (no. street, apt.)			
City/Town	Prov. **ON**	Postal Code	Telephone

C. Clinical Information

1. Indicate the provider/facility who provided first treatment: Date of First Treatment dd mm yyyy

2. Name of referring health professional (if applicable): Date of Referral dd mm yyyy

3. Patient's history of injury:

4. Describe patient's current symptoms:

5. Diagnosis/working diagnosis:

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

Low Back Injuries Program of Care Initial Assessment Report

Claim Number

C. Clinical Information (continued)

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

Start >

7. Are there any complicating factors that may delay recovery? ☐ Yes ☐ No

If **Yes,** please identify:

☐ Believes hurt equals harm ☐ Low mood/social withdrawal ☐ Home environment concerns ☐ Other: _____

☐ Fears/avoids activity ☐ Prefers passive treatments ☐ Work environment concerns

8. Describe relevant medical information (include medical history, medications, medical conditions, surgeries):

9. Administer and record Numeric Pain Rating Score at initial assessment: _____/10 (e.g. no pain =0 worst possible pain =10)

10. Indicate Range of Pain:

☐ No low back pain ☐ Low back pain without radiation ☐ Low back pain radiating no further than the knee ☐ Low back pain radiating below the knee, no neurological signs ☐ Low back pain radiating to a precise dermatome, with or without neurological signs

11. Administer and record patient's Roland - Morris Disability Questionnaire score at initial assessment: _____/24

12. Describe patient's limitations in Activities of Daily Living and/or significant changes (self-care, sleep history, participation and leisure, sports, and hobbies):

D. Treatment Plan & Return To Work Recommendation

13. Specify anticipated treatment plan (include type of intervention, intensity, frequency, duration):

Anticipate treatment beyond 4 weeks (Phase 2)? ☐ Yes ☐ No

14. Are you recommending referral(s) to other health professional(s)? ☐ Yes ☐ No

If **Yes,** provide name and contact information: _____

15. 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 to work: dd mm yyyy

16. Describe the patient's functional limitations:

A. ☐ No Limitations

B. ☐ Limitations (please specify) ☐ Lifting ☐ Sitting ☐ Climbing stairs/ladders ☐ Kneeling ☐ Standing ☐ Use of upper extremities ☐ Bending/twisting ☐ Other: _____

Comments: _____

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

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