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 Care & Outcomes Summary

Claim Number

Start >

A. Patient Information Section

Last Name	First Name	Init.

Date of Birth (dd mm yyyy) | Date of Injury (dd mm yyyy)

This report must be submitted WHENEVER the patient is discharged

A. Patient completed program of care? ☐ Yes **OR** **B.** Patient did not return/self-discharged from program of care? ☐ Yes

Specify date of last visit (dd mm yyyy)

B. Health Professional Billing Information

☐ Chiropractor ☐ Physiotherapist ☐ Other

Health Professional Name (please print)

Facility Name

Address (no. street, apt.)

City/Town | Prov. ON | Postal Code | Telephone No.

Date of Discharge (dd mm yyyy)

Service Code **LBCOS**

▼ Complete these fields if HST is applicable to this form ▼

HST Registration No.	Service Code	HST Amount Billed
	ONHST	**$**

WSIB Provider ID.

Your Invoice No.

C. Clinical Information

1. Summary of physical findings (including significant findings and changes from initial assessment):

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

3. 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

4. Administer and record patient's Roland - Morris Disability Questionnaire score at discharge: _____ /24

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

6. Has the patient physically returned to pre-injury level of overall function? ☐ Yes ☐ No

7. Are there any complicating factors that may delay 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: _____

8. Are there outstanding issues? ☐ Yes ☐ No If **Yes,** specify: _____

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

9. Indicate if additional treatment(s)/assessment(s) or referral(s) are required:

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

Low Back Injuries Program of Care Care & Outcomes Summary

Claim Number

D. Return To Work Information

10. Patient's current employment status: ☐ Regular duties OR ☐ Regular hours OR ☐ Modified duties ☐ Modified hours

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

Will the patient return to work? ☐ Yes ☐ No If **Yes,** specify date dd mm yyyy

11. Describe the patient's functional limitations:

A. ☐ No Limitations

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

Comments: _____

12. Indicate any additional recommendations for safe and sustainable return to work:

13. Has the patient made contact with the employer since the injury? ☐ Yes ☐ No

Provide relevant details:

14. Indicate type of contact you had with the employer: ☐ Verbal ☐ Written ☐ None

Where no contact has been made, please indicate reason: ☐ Could not reach ☐ Did not receive call back ☐ Contact not initiated

E. Summary of Care Delivered

Mark (x) in box for each Program of Care component delivered.

15. Indicate the total number of visits: Phase 1 _____ (weeks 1-4) Phase 2 _____(weeks 5-8)

16. Program of Care Interventions Supported By Evidence		**Phase 1 (weeks 1-4)**	**Phase 2 (weeks 5-8)**
01	reassurance	☐	☐
02	explanation of injury, positive course of recovery	☐	☐
03	promotion of daily activities	☐	☐
04	emphasis on restoration of function	☐	☐
05	instruction and supervision of stretching exercises	☐	☐
06	spinal manipulation	☐	☐
07	spinal mobilization	☐	☐
08	instruction on self-application of heat and ice	☐	☐
09	use of nonprescription analgesics and non-steroidal anti-inflammatory drugs	☐	☐
10	facilitation of transition to work activities	☐	☐
11	exercise graduated, structured, quota-based	☐	☐
17. Program of Care Interventions Not Supported By Evidence and Not Recommended			
20	acupuncture	☐	☐
21	bed-rest	☐	☐
22	electrical stimulation	☐	☐
23	flexion exercises	☐	☐
24	mechanical traction	☐	☐
25	ultrasound	☐	☐
26	transcutaneous electrical nerve stimulation (TENS)	☐	☐
27	other, please specify:_____	☐	☐

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