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wsib cspaat ONTARIO

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

or

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

Program of Care for Mild Traumatic Brain Injury Initial Assessment Report

Please PRINT in black ink.

Claim Number (if known)

Start >

A. Patient & Employer Information

Last Name	First Name		Init.
Address (no. street, apt.)			
City/Town	Prov.	Postal Code	Telephone No.
Date of Birth (dd mm yyyy)	Date of Accident (dd mm yyyy)	Gender ☐ M ☐ F	
Employer Name	Supervisor/Contact Name	Telephone No.	
Address (no. street, apt.)			
City/Town	Prov.	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	
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 ☐ Massage Therapist ☐ Occupational Therapist ☐ Physician ☐ Physiotherapist
☐ Psychologist ☐ RN (EC) ☐ Speech-Language Pathologist ☐ Other (specify) _____

Health Professional's Name (please print)			Date of this Assessment (dd mm yyyy)
Facility Name (if applicable)			WSIB Provider ID.
Address (no. street, apt.)			Your Invoice No.
City/Town			Service Code (select one) ☐ **MTBIAE** (Education Stream) ☐ **MTBIAT** (Treatment Stream)
Prov.	Postal Code	Telephone No.	HST Registration No.
			HST Amount Billed

C. Clinical Information

1. Indicate the health professional/facility who provided first treatment for mild traumatic brain injury: | Date of First Treatment (dd mm yyyy)

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

3. This assessment is:
☐ within 3 months of the accident date
☐ more than 3 months and less than 1 year of the accident date

4. Patient's history of injury:

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

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C. Clinical Information (continued)

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

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

7. Summary of self-reported symptoms (check all that apply):

Comments:

- ☐ Attention/Concentration
- ☐ Depressed
- ☐ Dizziness/Vertigo
- ☐ Double Vision
- ☐ Fatigue
- ☐ Forgetfulness/Poor Memory
- ☐ Frustrated/Impatient
- ☐ Headaches
- ☐ Irritability/Easily Angered
- ☐ Light Sensitivity
- ☐ Nausea and/or Vomiting
- ☐ Noise Sensitivity
- ☐ Restlessness
- ☐ Sleep Disturbance
- ☐ Taking Longer To Think
- ☐ Other (specify):_____

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

If **Yes,** please identify:

Comments:

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

9. Describe patient's limitations in activities of daily living and/or significant changes:

- ☐ Self Care _____
- ☐ Hobbies _____
- ☐ Child Care _____
- ☐ Other (specify): _____
- ☐ Sports/Leisure Activities _____
- ☐ Sleep Disturbance _____
- ☐ Housekeeping _____
- ☐ Communication _____

10. Working Diagnosis:

11. Administer and record: Rivermead Score _____ / 64 (Total of all scores excluding Other Difficulties)

Administer and record: RAND SF-36 Scores (see categories below)

- ☐ Emotional well-being _____ /100
- ☐ Energy/fatigue _____ /100
- ☐ General health _____ /100
- ☐ Pain _____ /100
- ☐ Physical functioning _____ /100
- ☐ Social function _____ /100
- ☐ Role limitations due to emotional problems _____ /100
- ☐ Role limitations due to physical health _____ /100

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

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D. Treatment Plan & Return To Work Recommendation

12. Nature of education provided to the patient:

1. Was an education session provided? ☐ Yes ☐ No
   Indicate length of education session _____
   Are further sessions scheduled? ☐ Yes ☐ No If **Yes**, date of next session? dd mm yyyy
2. Written educational material provided to patient? ☐ Yes ☐ No Explain:

13. 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

14. Describe the patient's functional limitations:

A. ☐ No Limitations

B. ☐ Limitations (please specify)

- ☐ Assembly line
- ☐ Climbing stairs/ladders
- ☐ Environmental
- ☐ Heights
- ☐ Lifting
- ☐ Operating machinery
- ☐ Operating motor vehicle
- ☐ Positional limitation of head and neck
- ☐ Standing
- ☐ Other (specify):

Comments:

15. Anticipate treatment beyond 3 months? ☐ Yes ☐ No

Specify anticipated treatment plan (include intensity, frequency, duration):

- ☐ Cognitive Rehabilitation _____
- ☐ Manual Mobilization Therapy _____
- ☐ Other _____

16. Will referral(s) be made to other health professional(s)? ☐ Yes ☐ No

If **Yes,** specify name and contact number: _____

- ☐ Chiropractor
- ☐ Massage Therapist
- ☐ Occupational Therapist
- ☐ Physician
- ☐ Physiotherapist
- ☐ Psychologist
- ☐ Registered Nurse (EC)
- ☐ Speech-Language Pathologist
- ☐ Other (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	Telephone	Date dd mm yyyy
Type your name and upload, or print and sign before returning to WSIB.		

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