



**Mild traumatic brain injury
program of care (mTBI POC)
mid-point report**

Claim number

A. Injured person information		
Last name	First name	Initials
Date of birth (dd/mmm/yyyy)	Date of injury (dd/mmm/yyyy)	Date(s) of initial assessment (dd/mmm/yyyy)
This report must be completed at the end of block 1		

B. Regulated health professional information		
<input type="checkbox"/> Chiropractor <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Other (specify) _____		
Name	Date of report (dd/mmm/yyyy)	
Facility name	Date of last treatment (dd/mmm/yyyy)	
Address (number, street, unit / suite)	WSIB provider ID	
City/town	Province	Service code MTBRMPR
Postal code	Telephone	Complete these fields if HST is applicable to this form
HST registration number		Service code ONHST
HST amount billed		

C. Functional information					
Administer and record the scores for the Patient-Specific Functional Scale (PSFS) for three to five functional activities, at least two of which are work-related. The PSFS is available at www.wsib.ca .					
Functional activity	Initial score	Mid-point score	Relevant physical demands / functional requirements	Clinician's assessment of current ability	
E.g. Lift from floor level	3/10	5/10	Lift 30 lb box from floor level, using both hands.	Can lift 25 lb from 8" elevation to hip level.	
1.	/10	/10			
2.	/10	/10			
3.	/10	/10			
4.	/10	/10			
5.	/10	/10			
Total: Divide the total score by the number of activities (minimum three activities)		/10	/10		

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

200 Front Street West, Toronto, Ontario, M5V 3J1

www.wsib.ca/upload | Toll free: 1-800-387-0750 | TTY: 1-800-387-0050 | Fax: 1-888-313-7373

10392A (09/20)

Claim number

Last name	First name	Initials
Date of birth (dd/mmm/yyyy)	Date of accident (dd/mmm/yyyy)	

D. Additional interventions and referral recommendations

1. If vestibular rehabilitation is currently being provided, or is recommended to be provided in block 2, provide objective findings from assessment, rationale for treatment and describe delivered and/or planned interventions:

2. Are you recommending additional referrals? yes no If **yes**, indicate below

<input type="checkbox"/> WSIB Community Mental Health Program (psychology) <input type="checkbox"/> Psychiatry <input type="checkbox"/> WSIB Neurology Specialty Program <input type="checkbox"/> WSIB Occupational Health Assessment Program (OHAP), mTBI Assessment	<input type="checkbox"/> Other WSIB Specialty Programs <input type="checkbox"/> WSIB Return to Work Specialist <input type="checkbox"/> Other (specify):
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Reason for referral:

mTBI POC regulated health professional signature	Date (dd/mmm/yyyy)
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