Mild traumatic brain injury program of care (mTBI POC) care & outcome summary

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)

You must submit this report upon completion of the mTBI POC or whenever the injured person is discharged

☐ Injured person completed mTBI POC ☐ Injured person did not return/self-discharged

Employment status at time of discharge:

A. ☐ Full time **or** ☐ Part time ☐ Not working
B. ☐ Regular duties **or** ☐ Modified duties
C. ☐ Regular hours **or** ☐ Modified hours

B. Regulated health professional information

☐ Chiropractor ☐ Occupational Therapist ☐ Physiotherapist ☐ Other (specify) _____

Name	Province	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		Service code **MTBRCOS**
Postal code	Telephone	Complete these fields if HST is applicable to this form
		HST registration number / Service code **ONHST**
		HST amount billed

C. Clinical information

1. Has the injured person returned to their pre-injury level of function? ☐ yes ☐ no

List any outstanding issues and/or symptoms:

2. Additional investigations and consultations since the initial assessment (provide details):

3. Response to treatment

☐ Fully recovered ☐ Significant improvement ☐ Minimal improvement ☐ No improvement ☐ Worsening

Provide details:

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

wsib ONTARIO | wsib.ca

Claim number

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

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

Testing	Normal exam	Findings and details
Musculoskeletal	☐ yes ☐ no	
Neurological	☐ yes ☐ no	
Balance	☐ yes ☐ no	
Vestibular	☐ yes ☐ no	
Other (specify)	☐ yes ☐ no	
Mental status and cognition:		
Functional status/exercise testing (if appropriate):		

5. Rivermead Post-Concussion Symptoms Questionnaire:

Total all scores excluding “other difficulties”. The Rivermead is available at www.wsib.ca. Score: /64

Comments:

6. In your assessment, did you observe/identify any complicating factors that may delay recovery? ☐ yes ☐ no

If **yes**, please identify:

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

7. Check all affected activities of daily living:

☐ Self care
☐ Meal preparation
☐ Shopping (groceries)
☐ Child care/care giving
☐ Housekeeping
☐ Household maintenance (e.g. outdoor maintenance, snow shovelling)
☐ Driving
☐ Leisure activities/sports
☐ Communication
☐ Computer/television use
☐ Reading

Comment on affected activities of daily living (e.g., current limitations compared with abilities prior to date of injury):

Upload forms and documents related to your claim at wsib.ca/upload

wsib ONTARIO wsib.ca

Claim number

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

D. Functional information

8. 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		Midpoint score	Discharge score	Relevant physical demands / functional requirements	Clinician's assessment of current ability
E.g.	Lift from floor level	3/10	9/10	Lift 30 lb box from floor level, using both hands.	Can lift 30 lb box but is slower than usual.
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		

E. Abilities, limitations and accommodations for return-to-work planning

9. Provide the injured person's functional abilities, limitations, restrictions and accommodations to facilitate return to work.

Physical	Limitations	Describe recommended accommodation
Sit/stand (duration of each / frequency of change)	☐ yes ☐ no ☐ na	
Lifting (weight/frequency, own pace or high demand)	☐ yes ☐ no ☐ na	
Walking (distance/time)	☐ yes ☐ no ☐ na	
Carrying	☐ yes ☐ no ☐ na	
Other (specify):	☐ yes ☐ no ☐ na	

Upload forms and documents related to your claim at wsib.ca/upload

wsib ONTARIO | wsib.ca

Claim number

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

Potential mTBI symptom triggers	Limitations	Describe recommended accommodation
Computer work (duration, frequency of breaks / other tasks)	☐ yes ☐ no ☐ na	
Visual tasks (reading, non-computer tasks)	☐ yes ☐ no ☐ na	
Lighting (brightness, fluorescent, etc.)	☐ yes ☐ no ☐ na	
Noise (continuous, impact, other)	☐ yes ☐ no ☐ na	
Interaction with public	☐ yes ☐ no ☐ na	
Interaction with co-workers	☐ yes ☐ no ☐ na	
Other (specify):	☐ yes ☐ no ☐ na	
Safety considerations	**Limitations**	**Describe recommended accommodation**
Work at heights	☐ yes ☐ no ☐ na	
Driving	☐ yes ☐ no ☐ na	
Operating machinery	☐ yes ☐ no ☐ na	
Other (specify):	☐ yes ☐ no ☐ na	

F. Additional referral recommendations

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

☐ WSIB Community Mental Health Program (psychology)
☐ Psychiatry
☐ WSIB OHAP mTBI Assessment
☐ WSIB Neurology Specialty Program, mTBI Assessment
☐ Other WSIB Specialty Programs
☐ WSIB Return to Work Specialist
☐ Other (specify):

Reason for referral:

11. Other comments:

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

Upload forms and documents related to your claim at wsib.ca/upload