Mild traumatic brain injury program of care (mTBI POC) Supplementary 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)

Injured person completed supplementary block   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	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 **MTBRST or MTBRSTV**
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.

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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. Are there 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):

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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	COS score	Current score	Relevant physical demands / functional requirements	Clinician's assessment of current ability
E.g.	Lift from floor level	3/10	10/10	Lift 30 lb box from floor level, using both hands.	Lift 30 lb box from floor level, using both hands.
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	

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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)

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