# 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

Number of sessions provided in this block:

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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