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wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail to:
200 Front Street W.
Toronto ON
M5V 3J1

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

Musculoskeletal Program of Care (MSK POC) Care & Outcomes Summary

Claim Number

For an injury to: (select one) ☐ Upper body (excluding the shoulder)
☐ Lower body (excluding the lower back)

Please PRINT in black ink.

A. Worker Information

start >

Last Name	First Name	Initials

Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)	☐ Worker completed MSK POC ☐ Worker did not return / self discharged from MSK POC

B. Health Professional Information

☐ Chiropractor ☐ Physiotherapist ☐ Other _____

Health Professional Name	WSIB Provider ID.
	Your Invoice No.
Facility Name	Date of Discharge dd mmm yyyy
Address (no. street, suite)	Service Code (select one) ☐ **MSKUCOS** - upper body ☐ **MSKLCOS** - lower body
City/Town	▼ Complete these fields if HST is applicable to this form ▼

Prov.	Postal Code	Telephone No.

HST Registration No.	Service Code	HST Amount Billed
	ONHST	**$**

C. Functional Information

1. Administer and record the scores for the Patient-Specific Functional Scale (PSFS) for 3-5 functional activities at least 2 of which are work-related. The PSFS is available on the WSIB web site at **www.wsib.on.ca**.

Date of intial assessment (dd/mmm/yyyy)	Date of final assessment (dd/mmm/yyyy)

	Functional Activity	Scores at initial Assessment	Scores at final Assessment	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 to hip 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 of 3 activities)		*/10*	*/10*		

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Worker's Last Name	Worker's First Name
Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)

Musculoskeletal Program of Care (MSK POC) Care & Outcomes Summary

Claim Number

C. Functional Information (cont'd)

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If yes, please describe:

D. Clinical Information

1. Change in pertinent clinical signs:

2. Other relevant clinical information:

E. Return to Work Information

1. a. At discharge is the worker able to perform all regular work duties and work hours? ☐ Yes ☐ No

b. ☐ This has been communicated with the worker.

2. a. If this worker is not able to perform all regular work duties and work hours, indicate the type of contact you had with WSIB.

☐ Verbal ☐ Written ☐ None ☐ Call confirmation number: _____

b. Name of WSIB contact	Date of contact (dd/mmm/yyyy)

3. What are your recommendations for work activities?

Regular duties	☐ Yes	☐ No	If no, enter expected date (dd/mmm/yyyy) →
Modified duties	☐ Yes	☐ No	If no, enter expected date (dd/mmm/yyyy) →
Regular hours	☐ Yes	☐ No	If no, enter expected date (dd/mmm/yyyy) →
Modified hours	☐ Yes	☐ No	If no, enter expected date (dd/mmm/yyyy) →

4. Has the worker returned to all regular work duties and all regular work hours? Yes ☐ No ☐

Comments

F. Summary of Care Delivered

1. Date of last visit (dd/mmm/yyyy)	**2.** Indicate the total number of visits:

3. Program of Care Interventions provided:	**Yes**	**No**
Education		
Activity Modification		
Exercise Therapy		
Manipulation and/or Mobilization		
Massage		
Electro / Thermal modalities		
Immobilization through bracing		

Health Professional's Signature *Type your name and upload, or print and sign before returning to WSIB.*	Date (dd/mmm/yyyy)

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