Musculoskeletal (MSK) program of care: Initial assessment report

Claim number

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Ce document est disponible en français sous le titre: *Rapport d'évaluation initiale* (10635B; 2023).

Injury to: ☐ Single MSK zone ☐ Multiple MSK zones (approval required)

A. Injured person and employer information			
Last name		First name	
Address (number, street, unit/suite)			
City/town	Province	Postal code	Telephone
Date of birth (dd/mm/yyyy)		Date of injury (dd/mm/yyyy)	
Job title/occupation		Current employment status: ☐ At work ☐ Off work	

B. Regulated health professional information			
Name	Profession		WSIB provider ID
Facility name	Telephone		Date of report (dd/mm/yyyy)
Address (number, street, unit/suite)			
City/town	Province	Postal code	Date of this assessment (dd/mm/yyyy)

C. Clinical information	
1. Referring regulated health professional (if applicable):	Date of referral (dd/mm/yyyy)
2. History of injury (provide details regarding mechanism of injury):	
3. Investigations, consultations, and treatment to date including medications:	

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Claim number

Last name	First name	Date of birth (dd/mm/yyyy)

C. Clinical information (continued)

4. Describe any relevant medical information (medical history, conditions, surgeries):

5. Describe the injured person's current symptoms:

6. Summary of physical assessment findings (include examination findings for all areas of injury):

Testing	Findings and details (include pertinent negative findings)
Hand dominance	☐ Right handed ☐ Left handed
Observation (e.g., posture, gait, immobilization status)	
Palpation and range of motion (ROM): (e.g., tenderness on palpation, passive ROM, active ROM, resisted ROM, etc.)	
Neurological testing: (e.g., sensory, motor reflexes, strength, neurological tests as needed)	
Relevant orthopedic/ special testing	

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C. Clinical information (continued)

6. Summary of physical assessment findings (include examination findings for all areas of injury):

Testing	Findings and details (include pertinent negative findings)
Other (specify)	

7. Provide occupational diagnosis(es):

8. Are there any factors that may delay the injured person's recovery and their return-to-work?

☐ Yes ☐ No

If **yes**, indicate below:

- ☐ Fear/avoidance of activity
- ☐ Co-morbid conditions
- ☐ Limited support
- ☐ Believes hurt equals harm
- ☐ Low mood/social withdrawal
- ☐ Does not feel ready to return to work
- ☐ "Medium to heavy" job duties
- ☐ Working conditions and/or shift work
- ☐ Difficulty transitioning from modified to pre-injury duties
- ☐ Does not feel current work duties are suitable

Other (specify):

D. Outcome measures

1. Complete at least one functional outcome measure that relates to the injured person's area(s) of injury. The same outcome measure(s) should be repeated throughout the treatment period.

Functional outcome measures	Score
☐ Neck Disability Index (NDI)	%
☐ Oswestry Low Back Pain Disability Questionnaire (ODI 2.1a version)	%
☐ QuickDASH Disability/Symptom	/100
QuickDASH Work Module	/100
☐ Lower Extremity Functional Scale (LEFS)	/80
☐ World Health Organization Disability Assessment Schedule (WHODAS 2.0-12 item version)	/48

Comments (provide interpretation, key findings, etc. from outcome measures used):

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Claim number

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E. Treatment plan and additional referral recommendations

1. Indicate expected treatment interventions:

☐ Education ☐ Pain and self-management strategies ☐ Activity modification

☐ Manual therapy ☐ Exercise therapy ☐ Other (specify):

Estimated frequency of treatment: times per week

Estimated duration of treatment: weeks

2. Are you recommending any additional referral for assessment or intervention? Where determined appropriate for the occupational injury, the WSIB will assist in facilitating access.

☐ Yes – provide details below ☐ No

3. Indicate the recovery and return-to-work goals for block 1:

4. Have you discussed returning to work with the injured person?

☐ Yes ☐ No

Outline discussion:

Regulated health professional signature	Date (dd/mmm/yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

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Claim number

Last name	First name	Date of birth (dd/mm/yyyy)

Regulated health professional last name	Regulated health professional first name	Date of this assessment (dd/mm/yyyy)

Abilities and restrictions for return-to-work planning

Abilities

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100-200 metres
- ☐ Other (specify):

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15-30 minutes
- ☐ Other (specify):

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes-1 hour
- ☐ Other (specify):

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5-10 steps
- ☐ Other (specify):

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Limited – 0-5kg
- ☐ Light – 5-10kg
- ☐ Medium – 10-20kg
- ☐ Heavy >20kg
- ☐ Other (specify):

Lifting waist to shoulder:
- ☐ Full abilities
- ☐ Limited – 0-5kg
- ☐ Light – 5-10kg
- ☐ Medium – 10-20kg
- ☐ Heavy >20kg
- ☐ Other (specify):

Lifting above shoulder:
- ☐ Full abilities
- ☐ Limited – 0-5kg
- ☐ Light – 5-10kg
- ☐ Medium – 10-20kg
- ☐ Heavy >20kg
- ☐ Other (specify):

Pushing/pulling:
- ☐ Full abilities
- ☐ Limited – 0-5kg
- ☐ Light – 5-10kg
- ☐ Medium – 10-20kg
- ☐ Heavy >20kg
- ☐ Other (specify):

Ladder climbing:
- ☐ Full abilities
- ☐ 1-3 steps
- ☐ 4-6 steps
- ☐ Other (specify):

Ability to drive a car:
- ☐ Yes
- ☐ No – please explain:

Ability to use public transit:
- ☐ Yes
- ☐ No – please explain:

Restrictions ☐ None

☐ **Bending/twisting repetitive movement of** (please specify)**:**

Frequency: ☐ Occasional (1-33%) ☐ Frequent (34-66%) ☐ Constant (67-100%)

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Abilities and restrictions for return-to-work planning (continued)

Restrictions

☐ **Use of hand(s):**

Left		Right
☐	Gripping	☐
☐	Pinching	☐
☐	Other (please specify):	☐

Frequency: ☐ Occasional (1-33%) ☐ Frequent (34-66%) ☐ Constant (67-100%)

☐ **Operating motorized equipment** (e.g., forklift)**:**

☐ **Work at heights:**

☐ **Exposure to vibration:**
☐ Whole body ☐ Hand/arm

Additional comments on abilities and restrictions:

Estimated time frame for above abilities and restrictions:

Regulated health professional signature	Date (dd/mmm/yyyy)

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