



**Musculoskeletal (MSK) program of care:
Care and outcomes summary**

Claim number

Submit this form and supporting documents at wsib.ca/submit.

Ce document est disponible en français sous le titre: *Sommaire des soins et des résultats* (10637B; 2023).

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

A. Injured person information

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

You must submit this report upon completion of the MSK program of care or whenever the injured person is discharged.

Injured person has completed the MSK program of care		Injured person did not return/self-discharged	
Current employment status: At work Off work		Number of sessions provided in block 2:	

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 last treatment session (dd/mm/yyyy)	

C. Clinical information

1. Response to treatment to date:

Fully recovered (from workplace injury)	Significant improvement
Minimal improvement	No improvement Worsening

Provide details:

2. 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)	

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

Last name	First name	Date of birth (dd/mm/yyyy)
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C. Clinical information (continued)

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

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

3. Provide occupational diagnosis(es):

4. 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):

Last name	First name	Date of birth (dd/mm/yyyy)
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Regulated health professional last name	Regulated health professional first name	Date of this assessment (dd/mm/yyyy)
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Abilities and restrictions for return-to-work planning

Abilities

<p>Walking: Full abilities Up to 100 metres 100-200 metres Other (specify):</p>	<p>Standing: Full abilities Up to 15 minutes 15-30 minutes Other (specify):</p>	<p>Sitting: Full abilities Up to 30 minutes 30 minutes-1 hour Other (specify):</p>
<p>Stair climbing: Full abilities Up to 5 steps 5-10 steps Other (specify):</p>	<p>Lifting from floor to waist: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):</p>	<p>Lifting waist to shoulder: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):</p>
<p>Lifting above shoulder: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):</p>	<p>Pushing/pulling: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):</p>	<p>Ladder climbing: Full abilities 1-3 steps 4-6 steps Other (specify):</p>
<p>Ability to drive a car: Yes No – please explain:</p>	<p>Ability to use public transit: Yes No – please explain:</p>	

Restrictions None

Bending/twisting repetitive movement of (please specify):

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

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

Summarize changes in functional abilities since mid-point report:

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