



## Musculoskeletal (MSK) program of care: Initial assessment report

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

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

A. Injured person and employer informa	ition							
Last name				First name				
Address (number, street, unit/suite)								
City/town	Province Posta			I code	Telephone	Telephone		
Date of birth (dd/mm/yyyy)		Date of injury	e of injury (dd/mm/yyyy)					
Job title/occupation		Current employment status:  At work Off work						
B. Regulated health professional inform	ation							
Name		Professi	ion				WSIB provider ID	
Facility name Tele			Telep	hone Date of report (dd/mm/yyyy)			eport (dd/mm/yyyy)	
Address (number, street, unit/suite)					l			
City/town	Province		Posta	Date of this assessment (dd/mm/yyyy)			sment (dd/mm/yyyy)	
C. Clinical information								
Referring regulated health profession	nal (if app	olicable):			I	Date of re	eferral (dd/mm/yyyy)	
2. History of injury (provide details rega	arding me	chanism	of inju	ıry):				
3. Investigations, consultations, and tre	eatment to	o date ind	cluding	g medications:				

С	la	ai	n	n	n	u	m	ıb	er	



La	st name	First name	)	Date of birth (dd/mm/yyyy)				
	C. Clinical information (continued)  4. Describe any relevant medical information (medical history, conditions, surgeries):							
	·	`	<i>,</i> , , <b>c</b>					
5.	Describe the injured person's curren	it symptoms:						
6.	Summary of physical assessment fir	= :	<u> </u>	eas of injury):				
	Testing Hand dominance	Right handed	Left handed	Tunent negative initings)				
	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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Last name	First name	Date of birth (dd/mm/yyyy)	
C. Clinical information (continued)			
<b>6.</b> Summary of physical assessment f	indings (include examination findings for	r all areas of injury):	
Testing	Findings and details (include pertinent negative findings)		
Other (specify)			
7. Provide occupational diagnosis(es)	:		
<ol><li>Are there any factors that may dela</li></ol>	y the injured person's recovery and thei	r return-to-work?	
Yes No			
If <b>yes</b> , indicate below:			

Does not feel ready to return to work

Working conditions and/or shift work

Difficulty transitioning from modified to pre-injury duties

Does not feel current work duties are suitable

"Medium to heavy" job duties

Other (specify):

## D. Outcome measures

Fear/avoidance of activity Co-morbid conditions

Believes hurt equals harm

Low mood/social withdrawal

Limited support

**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):

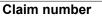
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Last name		First name		Date of birth (dd/mm/yyyy)
E. Treatment plan and addition	onal referral recomm	endations		
1. Indicate expected treatme	ent interventions:			
Education	Pain and self-man	agement strategies	Activity modification	
Manual therapy	Exercise therapy	Other (specify):		
Estimated frequency of treat	ment:	times per week		
Estimated duration of treatm	ient:	weeks		
2. Are you recommending an occupational injury, the WSI			ention? Where determine	ned appropriate for the
Yes – provide detail	s below	No		
3. Indicate the recovery and	return-to-work goal	s for block 1:		
<b>4.</b> Have you discussed retur	ning to work with th	e injured person?		
Yes No				
Outline discussion:				
Regulated health profession	al signature		D	ate (dd/mmm/yyyy)
Check this box if you a fill out your name and		submitting this form electro	onically. This represent	s your signature. You must

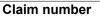
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Last name	First name		]	Date of birth (dd/mm/yyyy)
Regulated health professional last name	Regulated health pr	th professional first name Date of		assessment (dd/mm/yyyy)
Abilities and restrictions for return-to-work	planning			
Abilities	Ctandina		Citting	
Walking:	Standing: Full abilities		Sitting:	lition
Full abilities			Full abi	
Up to 100 metres	Up to 15 minut		•	0 minutes
100-200 metres	15-30 minutes			utes-1 hour
Other (specify):	Other (specify)	).	Other (	specify):
Stair climbing:	Lifting from floo	r to waist:	_	nist to shoulder:
Full abilities	Full abilities		Full abi	
Up to 5 steps	Limited – 0-5kg			– 0-5kg
5-10 steps	Light – 5-10kg		Light –	
Other (specify):	Medium – 10-2	20kg		n – 10-20kg
	Heavy >20kg		Heavy :	•
	Other (specify):		Other (	specify):
Lifting above shoulder:	Pushing/pulling	:	Ladder cl	imbing:
Full abilities	Full abilities		Full abi	lities
Limited – 0-5kg	Limited – 0-5kg	g	1-3 ste	os
Light – 5-10kg	Light – 5-10kg		4-6 ste	ps
Medium – 10-20kg	Medium – 10-2	_		specify):
Heavy >20kg	Heavy >20kg			
Other (specify):	Other (specify)	):		
Ability to drive a car:		Ability to use pub	olic transit:	
Yes		Yes		
No – please explain:		No – please exp	olain:	
Restrictions None				
	ment of (please spec	cify):		
Bending/twisting repetitive move	ment of (please spe	cify):		
Frequency: Occasional (1-33%	) Frequent (34	4-66%) Consta	ant (67-100%	(o)

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Last name		First name			Date of birth (dd/mm/yyyy)
Regulated health pro	ofessional last name	Regulated health profession	nal first name	Date of this	s assessment (dd/mm/yyyy)
Abilities and restricti	ons for return-to-work	planning (continued)			
Restrictions					
Use of hand(	s):				
Left		Right			
	Gripping				
	Pinching				
Oth	ner (please specify):				
Frequency:	Occasional (1-33%)	Frequent (34-66%)	Consta	ant (67-100%	%)
Operating me	otorized equipment (e	e.a forklift):			
Work at heig	hts:		Expos	sure to vibra	ation:
			V	/hole body	Hand/arm
Additional commer	nts on abilities and re	strictions:			
Estimated time fram	ne for above abilities	and restrictions:			
Regulated health pro	ofessional signature			Da	ate (dd/mmm/yyyy)
	ι if you are completing me and the date above	and submitting this form elec	ctronically. This	s represents	your signature. You must

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