

Date of last treatment session (dd/mm/yyyy)



Injury to:

City/town

Single MSK zone

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

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

Multiple MSK zones (approval required)

A. Injured person information				
Last name		First name		
Date of birth (dd/mm/yyyy)	Date of injury (dd/mm	/уууу)	Date of initial asse	essment (dd/mm/yyyy)
You must submit this report upon c is discharged.	ompletion of the MSI	(program of ca	re or whenever th	e injured person
Injured person has completed	the MSK program of c	are Inju	ured person did not	return/self-discharged
Current employment status:	Number of sessions provided in block 2:			
At work Off work				
B. Regulated health professional inform	nation			
Name	Profession			WSIB provider ID
Facility name	Tele	ephone	Date of r	eport (dd/mm/yyyy)
Address (number, street, unit/suite)				

C. Clinical information			
1. Response to treatment to date:	Fully recovered (from work	Significant improvement	
	Minimal improvement	No improvement	Worsening
Provide details:			

Postal code

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

Province

Testing	Findings and details (include pertinent negative findings)						
Hand dominance	Right handed	Left handed					
Observation (e.g., posture, gait, immobilization status)							

Contact <u>accessibility@wsib.on.ca</u> if you require this communication in an alternative format. Ce document est disponible en français sous le titre: *Sommaire des soins et des résultats* (10637B; 2023).



Last name	First name	Date of birth (dd/mm/yyyy)						
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 th	e injured person's recovery and their re	eturn-to-work?						
If yes , indicate below:								
Fear/avoidance of activity Co-morbid conditions Limited support Believes hurt equals harm Low mood/social withdrawal	-	job duties						
Other (specify):								

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

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 QuickDASH Work Module	/100 /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):

E.	Additional	referral	and	recovery	recommen	dations
	Additional	ICICIIAI	ullu	1000101		iuutioiis

1 . A	re you	recom	ımendin	g any	addition	al referra	al for	assessment	or	intervention?	Where	determined	appropri	ate for
the	occupa	ational	injury, t	he WS	SIB will a	ssist in f	acilit	ating access						

Yes - provide details below

No

2. Are you recommending a supplementary block of treatment?

Yes – Contact a WSIB Clinical Expert

No - No further treatment needed

If yes, indicate treatment frequency, duration and recovery and return-to-work goals:

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

Yes

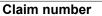
Outline discussion:

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.

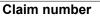
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Last name	First name	Date of birth (dd/mm/yyyy)			
Regulated health professional last name	Regulated health professional first nam	e Date of this assessment (dd/mm/yyyy)			
Abilities and restrictions for return-to-work	planning				
Abilities					
Walking:	Standing:	Sitting:			
Full abilities	Full abilities	Full abilities			
Up to 100 metres	Up to 15 minutes	Up to 30 minutes			
100-200 metres	15-30 minutes	30 minutes-1 hour			
Other (specify):	Other (specify):	Other (specify):			
Stair climbing:	Lifting from floor to waist:	Lifting waist to shoulder:			
Full abilities	Full abilities	Full abilities			
Up to 5 steps	Limited – 0-5kg	Limited – 0-5kg			
5-10 steps	Light – 5-10kg	Light – 5-10kg			
Other (specify):	Medium – 10-20kg	Medium – 10-20kg			
	Heavy >20kg	Heavy >20kg			
	Other (specify):	Other (specify):			
Lifting above shoulder:	Pushing/pulling:	Ladder climbing:			
Full abilities	Full abilities	Full abilities			
Limited – 0-5kg	Limited – 0-5kg	1-3 steps			
Light – 5-10kg	Light – 5-10kg	4-6 steps			
Medium – 10-20kg	Medium – 10-20kg	Other (specify):			
Heavy >20kg	Heavy >20kg				
Other (specify):	Other (specify):				
Ability to drive a car:	Ability to use p	oublic transit:			
Yes	Yes				
No – please explain:	No – please	explain:			
Restrictions None					
Bending/twisting repetitive move	ment of (please specify):				
Bending/twisting repetitive move	ment of (please specify):				
Frequency: Occasional (1-33%)	Frequent (34-66%) Cor	nstant (67-100%)			

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Last name	First name	Date of birth (dd/mm/yyyy)
Regulated health professional last name R	legulated health professional first name	Date of this assessment (dd/mm/yyyy)
Abilities and restrictions for return-to-work pla	anning (continued)	
Restrictions		
Use of hand(s):		
	ight	
Gripping		
Pinching		
Other (please specify):		
Frequency: Occasional (1-33%)	Frequent (34-66%) Cons	stant (67-100%)
Operating motorized equipment (e.g	g., iorkiitj.	
Work at heights:	Exp	osure to vibration:
		Whole body Hand/arm
Additional comments on abilities and rest		
Estimated time frame for above abilities a	nd restrictions:	
Summarize changes in functional abilities	s since mid-point report:	
Regulated health professional signature		Date (dd/mmm/yyyy)
Check this box if you are completing ar fill out your name and the date above.	nd submitting this form electronically. T	his represents your signature. You must

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