

## Interdisciplinary team program of care: Supplementary report Submit this form and supporting documents at <a href="wsib.ca/submit">wsib.ca/submit</a>.

A. Injured person information						
Last name		First name				
Date of birth (dd/mm/yyyy)	Date of injury (dd/n	nm/yyyy)	Date of in	itial assess	ment (dd/mm/yyyy)	
Submit this form when the person has	completed the inte	erdisciplinary team pr	ogram of	care or w	hen discharged.	
Injured person has completed this p	rogram of care	Injured person did	d not retur	n/self-disch	narged	
Area(s) being treated:		Current employment	status:			
		At work		Off wo	rk	
Supplementary block number:		Number of sessions	provided	in supplem	entary block:	
B. Regulated health professional information	n .					
Team lead name and profession		Other team member(s)	name an	d professio	n	
				-		
Facility name		Telephone		WSIB prov	/ider ID	
. asing name						
Address (number, street, unit/suite)	City/town		Provin	ce	Postal code	
radioss (names), suces, amesans)	Gity/term:				l octal octa	
Date of report (dd/mm/yyyy)		Date of last treatment session (dd/mm/yyyy)				
Date of report (da/mm/yyyy)		Date of last treatment c	00001011 (0	і ш/ і і і і і і / у у у у	,	
C. Clinical information						
1. What treatment interventions have you	delivered?					
2. Overall, response to treatment to date:						
Fully recovered (from workplace inju Minimal improvement	ıry) Significaı No impro	int improvement ovement		Moderate improvement Worsening		
Provide details on treatment goals and pro	ogress:					

Contact <a href="mailto:accessibility@wsib.on.ca">accessibility@wsib.on.ca</a> if you require this communication in an alternative format.

Ce document est disponible en français sous le titre : Programme de soins assuré par une équipe interdisciplinaire : Rapport complémentaire, 10714B (11/23)

_						
5	ıa	ım	n	ur	ทธ	er



Last name					First	First name						
C. Clinical information (con	tinued)				<u>'</u>							
3. Describe the person's c		mptoms	:									
4. Describe any impact on												
<ul><li>5. Identify and describe an</li><li>6. Summary of physical as</li></ul>								as of inj	ury):			
Testing			Findi	ngs and	l details	(includ	e releva	nt nega	tive find	ings)		
Hand dominance		Right-	handed			Left-h	nanded			Ambio	dextrous	
Observation and palpation (e.g., posture, gait, immobilization status)												
		lr	nitial ass	sessmer	nt			Cı	urrent as	sessme	ent	
Area of body/joint movement	Active of m		Passive of me		Stre tes		Active range Passive rang of motion of motion			e Strength testing		
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left
Limiting factor(s)/comment		motor re	eflexes, r	neurodyr	namic te	sting):						

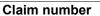
10714A Page 2 of 7

1	۱.	:.~		٠.		~	<b>L</b> .	_	-
ا ح	ıa	iπ	1 1	ш	JI.	Ш	U	e	Г



Last name	First name		
C. Clinical information (continued)			
Relevant orthopedic/special testing:			
Other (specify):			
D. Outcome measures			
Complete at least one functional outcome measure that relates measure(s) throughout the treatment period.	s to the person's area(s) of injury.	Repeat the san	ne outcome
		Initial assessment score	Current score
Neck Disability Index (NDI)			
<b>Level of disability:</b> 0 to 4 (0-8%) = none; 5 to 14 (10-28%) = moderate; 25 to 34 (50-64%) = severe; above 34 (70-100%)		%	%
Oswestry Low Back Pain Disability Questionnaire (ODI 2.1	a version)		
<b>Level of disability:</b> 0-20% = minimal; 21-40% = moderate; 4 61-80% = crippled; 81-100% = bed bound/exaggerating sym	•	%	%
QuickDASH Disability/Symptom		/100	/100
QuickDASH Work Module		/100	/100
The higher the score, the greater the disability			<u></u>
Lower Extremity Functional Scale (LEFS)		/00	/90
The lower the score, the greater the disability		/80	/80
World Health Organization Disability Assessment Schedule (WHODAS 2.0-12 item version)		/48	/48
The higher the score, the greater the disability			
<b>Where clinically indicated</b> , complete the applicable anxiety/n treatment period.	nood/pain measure(s). Repeat as	needed through	hout the
Generalized Anxiety Disorder-7 (GAD-7)			
Level of anxiety symptoms: 0 to 9 = none to mild; 10 to 14	= moderate; 15 to 21 = severe	/21	/21
Patient Health Questionnaire-9 (PHQ-9)			
<b>Level of depressive symptoms:</b> 0 to 4 = none; 5 to 9 = mile 20 to 27 = severe	d; 10 to 14 = moderate;	/27	/27
Pain Self-Efficacy Questionnaire (PSEQ)			
Lower scores indicate lower self-efficacy and lower levels of	confidence in dealing with pain	/60	/60
Comments (provide interpretation, key findings, etc. from outcor	me measures used):		

10714A Page 3 of 7





ONTARIO I							
Last name		First name					
E. Diagnosis and prognosis							
Provide occupational diagnosis	s(es) and prognosis(es).						
Diagnosis(es)	Prognosi	is	Expected timeframe and rationale				
J.11 <b>.9</b> .100.10(00)	e.g., expecting full functional partial recovery; not expecting	recovery; expecting	Support with clinical findings and recovery barriers				
2. Are there any factors that may	delay the person's recovery a	nd their return to worl	k? Yes No				
If <b>yes</b> , indicate below:							
Fear/avoidance of activity Co-morbid conditions Limited support Believes hurt equals harm Low mood	onditions "Medium to heavy" job duties oort Working conditions and/or shift work						
Other (please specify):							
F. Additional referral and recovery	recommendations						
			We can help the person access other				
2. Are you recommending a supp Yes - please call us for pre-a		her treatment needed	l				
·							
If <b>yes</b> , indicate the rationale for a	dditional treatment and goals:						
Estimated frequency of treatment	t: times per week						
Estimated duration of treatment:		quested supplementa	ry block start date:				

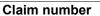
10714A Page 4 of 7





Last name	First name
F. Additional referral and recovery recommendations (continued	
Did you communicate with other treating health care profess contracted providers, orthopedic surgeon, family physician, Yes No N/A	sionals (e.g., musculoskeletal program of care provider, other
If <b>yes</b> , outline discussion:	
If there are questions or concerns about the information provide	ded in this report, please call
at	
G. Signatures	
Team lead regulated health professional name and signature	Regulated health professional name and signature
Date (dd/mmm/yyyy)	Date (dd/mmm/yyyy)
Check this box if you are completing and submitting this fill out your name and the date above.	form electronically. This represents your signature. You must

10714A Page 5 of 7





Last name	First name

	s for return-to-work planning				
Abilities					
Walking: Full abilities Up to 100 metres 100-200 metres Other (specify):	Standing: Full abilit Up to 15 15-30 mi Other (sp	minutes inutes	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):	Full abilities Up to 5 steps 5-10 steps Full abilities Limited – 0-5k Light – 5-10kg		Lifting waist to shoulder: Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):		
Lifting above should Full abilities Limited – 0-5kg Light – 5-10kg Medium – 10-20kg Heavy >20kg Other (specify):	Full abilit Limited - Light – 5	ties - 0-5kg -10kg – 10-20kg 20kg	Ladder climbing: Full abilities 1-3 steps 4-6 steps Other (specify):		
Ability to drive a car: Yes No – please explain:		Yes	Ability to use public transit: Yes No – please explain:		
Restrictions Non	e				
Bending/twisting rep	etitive movement of (please s	pecify):			
Frequency: Oc	casional (1-33%) Freque	ent (34-66%)	Constant (67-100%)		

10714A Page 6 of 7

1	۱.	:.~		٠.		~	<b>L</b> .	_	-
ا ح	ıa	iπ	1 1	ш	JI.	Ш	U	e	Г



Last name		First name	
	or return-to-work planning (contin	ued)	
Restrictions			
Use of hand(s):			
Left	Right		
Grip	pping		
Pino	ching		
Other (plea	se specify):		
Frequency: Occas	sional (1-33%) Frequent	(34-66%) Constant (67-100%	)
Operating motorized eq	uipment (e.g., forklift):		
	,		
Chemical exposure to:	Environmental exposure	Potential side effects from	Exposure to vibration:
onomical expectate ter	to (e.g., heat, cold, noise	medications (please specify):	-
	or scents):		Whole body
			Hand/arm
		<b>Note:</b> do not include the name of medications.	
Additional comments on a	bilities and restrictions:		
Estimated time frame for a	bilities and restrictions:		
Summarize changes in fun	ectional abilities since previous	s report:	
I. Signature			
	professional name and signature	2	Date (dd/mmm/yyyy)
	v		
Check this box if you a	are completing and submitting th	is form electronically. This represents	your signature. You must

10714A Page 7 of 7

fill out your name and the date above.