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

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)	

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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):

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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%)

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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 last report:

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