

Claim	number	

A. Injured person information											
Last name			First name)			Initials				
Date of birth (dd/mmm/yyyy)	nmm/yyyy)		Date(s) of initia	al assessment (dd/mm	nm/yyyy)						
You must submit this rep	You must submit this report upon completion of the mTBI POC or whenever the injured person is discharged										
☐ Injured person completed mTBI P	ОС	□ Inju	ıred perso	n did not return/s	elf-discharged						
Employment status at time of discharg	e:										
A. Full time or Part time Not working B. Regular duties or Modified duties C. Regular hours Modified hours											
B. Regulated health professional in	formation										
☐ Chiropractor ☐ Occupation	nal Therapist	t □ Physic	otherapist	☐ Other (s	pecify)						
Name				Date of report (c	dd/mmm/yyyy)						
Facility name				Date of last trea	tment (dd/mmm	n/yyyy)					
Address (number, street, unit / suite)				WSIB provider I	D						
City/town		Province		Service code MTBRCOS							
Postal code	Telephone			Complete these fields if HST is applicable to this form							
	-			HST registration	number	Service code					
						ONHST					
				HST amount bill	led						
C. Clinical information											
1. Has the injured person returned to t	heir pre-iniu	rv level of function	on?	yes	no						
List any outstanding issues and/or s		,		,							
	,p										
2 Additional investigations and consul	4-4ii										
2. Additional investigations and consul	tations since	e the initial asses	ssment (pr	ovide details):							
3. Response to treatment											
☐ Fully recovered ☐ Significant i	mprovemen	t □ Minima	l improven	nent 🗆 No	o improvement	☐ Worsening	l				
Provide details:											

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



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Last name			First name				
Date of birth (dd/mmm/yy	уу)		Date of accident (dd/mm	nm/yyyy)	1		
			1				
4. Summary of physical fi							
Testing	Normal exam	1	Findings and details				
Musculoskeletal	yes no						
Neurological	yes no						
Balance	yes no						
Vestibular	yes no						
Other (specify)	yes no	,					
Mental status and cogniti	on:						
Functional status/exercis	e testing (if approp	riate):					
5. Rivermead Post-Concu	ıssion Symptoms (Questionnaire:					
Total all scores excluding	"other difficulties".	The Rivermead is a	vailable at www.wsib.ca. S	Score: /64			
Comments:							
6. In your assessment, die	d you observe/iden	tify any complicating	factors that may delay re	covery? yes no			
If yes , please identify:				•			
☐ Believes hurt equals ha ☐ Fears/avoids activity ☐ Low mood/social withd ☐ Prefers passive treatm	rawal	☐ Home environme ☐ Changes in relat ☐ Work environme ☐ Other (specify):	tionship dynamics				
7. Check all affected activ	ities of daily living:						
☐ Self care ☐ Meal preparation ☐ Shopping (groceries) ☐ Child care/care giving	□ House	ekeeping ehold maintenance (e enance, snow shovel g		☐ Leisure activities/sports☐ Communication☐ Computer/television use☐ Reading			
Comment on affected act	vities of daily livinç	g (e.g., current limitati	ions compared with abilition	es prior to date of injury):			

① Upload forms and documents related to your claim at wsib.ca/upload

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D. Functional information

8. Administer and record the scores for the Patient-Specific Functional Scale (PSFS) for three to five functional activities, at least two of which are work-related. The PSFS is available at www.wsib.ca.

	Functional activity	Midpoint score	Discharge score	Relevant physical demands / functional requirements	Clinician's assessment of current ability
E.g.	Lift from floor level	3/10	9/10	Lift 30 lb box from floor level, using both hands.	Can lift 30 lb box but is slower than usual
1.		/10	/10		
2.		/10	/10		
3.		/10	/10		
4.		/10	/10		
5.		/10	/10		
	tal: Divide the total score	/10	/10		

by the number of activities (minimum three activities)

/10 /10

E. Abilities, limitations and accommodations for return-to-work planning

9. Provide the injured person's functional abilities, limitations, restrictions and accommodations to facilitate return to work

Physical	Limitations			Describe recommended accommodation
Sit/stand (duration of each / frequency of change)	yes	no	na	
Lifting (weight/frequency, own pace or high demand)	yes	no	na	
Walking (distance/time)	yes	no	na	
Carrying	yes	no	na	
Other (specify):	yes	no	na	

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Potential mTBI symptom triggers Limitations				Describe recommended accommodation				
Computer work (duration, frequency of breaks / other tasks)	yes	no	na					
Visual tasks (reading, non-computer tasks)	yes	no	na					
Lighting (brightness, fluorescent, etc.)	yes	no	na					
Noise (continuous, impact, other)	yes	no	na					
Interaction with public	yes	no	na					
Interaction with co-workers	yes	no	na					
Other (specify):	yes	no	na					
Safety considerations	Lin	nitatior	าร	Describe recommended accommodation				
Work at heights	yes	no	na					
Driving	yes	no	na					
Operating machinery	yes	no	na					
Other (specify):	yes	no	na					
F. Additional referral recommendations								
10. Are you recommending additional refer	rals?	ye	s	no If yes , indicate below				
 □ WSIB Community Mental Health Progra □ Psychiatry □ WSIB OHAP mTBI Assessment □ WSIB Neurology Specialty Program, m¹ 				☐ Other WSIB Specialty Programs☐ WSIB Return to Work Specialist☐ Other (specify):				
Reason for referral:								
11. Other comments:								
mTBI POC regulated health professional signature Date (dd/mmm/yyyy)								

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