wsib cspaat ONTARIO

Fax To:
416-344-4684
OR 1-888-313-7373

Claim Number (If known)

8 Health Professional's Report (Form 8)

A. Patient and Employer Information - (Patient to complete Section A)

Last Name	First Name	Init.	Sex
			☐ M ☐ F

Address (no., street, apt.)	City/Town	Prov.	Postal Code
		ON	

Telephone	Social Insurance No.	Date of Birth (dd mm yyyy)	Language
			☐ Eng. ☐ Fr. ☐ Other

Employer Name

The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the Workplace Safety and Insurance Act. The Social Insurance Number may be used to identify workers and to issue income tax information statements as authorized by the Income Tax Act. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.

B. Incident Dates and Details Section

1. How did the injury/reinjury or illness occur at work?

Occupation

Date of incident/or when did the symptoms start? (dd mm yyyy)

C. Clinical Information Section - (Please check all that apply)

1. Area of Injury/Illness

☐ Brain
☐ Head
☐ Face
☐ Eyes
☐ Other:

☐ Ears
☐ Teeth
☐ Neck
☐ Chest

☐ **Upper back**
☐ **Lower back**
☐ Abdomen
☐ Pelvis

Left		Right
☐	**Shoulder**	☐
☐	Arm	☐
☐	Elbow	☐
☐	Forearm	☐

Left		Right
☐	Wrist	☐
☐	Hand	☐
☐	Fingers	☐

Left		Right
☐	Hip	☐
☐	Thigh	☐
☐	Knee	☐
☐	Lower Leg	☐

Left		Right
☐	Ankle	☐
☐	Foot	☐
☐	Toes	☐

2. Description of Injury/Illness Physical Examination Findings

☐ Pain at rest/Night Pain

Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10

☐ Abrasion
☐ Amputation
☐ Bite
☐ Burn
☐ Contusion/Hematoma/Swelling
☐ Crush Injury

☐ Disc Herniation
☐ Dislocation
☐ **Fall from Height**
☐ Foreign Body
☐ **Fracture**
☐ Hernia
☐ Infection

☐ Inflammation
☐ Internal Joint Derangement
☐ Joint Effusion
☐ Laceration
☐ **Neurological Dysfunction**
☐ Psychological
☐ Puncture (non-needlestick)

☐ Repetitive Strain Injury
☐ Spinal Cord Injury
☐ Sprain/Strain
☐ **Surgical Intervention**
☐ Tendonitis/Tenosynovitis
☐ ▼ Range of Motion

☐ Other

Exposure/Illness

☐ Asthma
☐ Cancer
☐ Fumes - Inhalation
☐ Hand-arm Vibration
☐ Hearing Loss
☐ Infectious Disease
☐ Needle Stick
☐ Poisoning/Toxic Effects
☐ Skin Condition

3. Are you aware of any pre-existing or other conditions/factors that may impact recovery? ☐ yes ☐ no

If yes, describe

4. Diagnosis

D. Treatment Plan

1. What is the treatment plan (type of treatment, duration) including prescribed medications?

2. To be completed by physicians only.

Work Injury/Illness Medications	Dose	Frequency	Duration	Work Injury/Illness Medications	Dose	Frequency	Duration
1.				3.			
2.				4.			

3. Investigations & Referrals:

☐ None ☐ Labs ☐ Xrays ☐ CT Scan ☐ MRI ☐ EMG ☐ Ultrasound ☐ Other

☐ FP/GP
☐ Specialist/ Specialty
☐ Chiropractor

☐ Occupational Health Centre
☐ Occupational Therapist
☐ Other

☐ Physiotherapist
☐ Psychologist

Would the patient benefit from the following referrals?
☐ Specialty Clinic
☐ Regional Evaluation Centre (REC)

Name of Referral or Facility (if known)	Telephone	Appointment Date (dd mm yyyy)

E. Billing Section

Health Professional Designation
☐ Chiropractor ☑ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class)

Service Code: **8M** | WSIB Provider ID:

HST Registration No.	HST Amount Billed (if applicable)	Service Code	Your Invoice No.	Service Date (dd mm yyyy)
	$	ONHST		30/05/2021

Health Professional Name (please print)

Address: 459 Hume St, Collingwood, ON L9Y 1W9

Telephone: 705-444-8606

Fax:

wsib cspaat ONTARIO

Claim Number (If known)

8 Health Professional's Report (Form 8)

Return To Work Information

Once completed, please ensure that a copy of this page only is provided to the worker.

Last Name	First Name	Init.	Birth Date dd mm yyyy

Area(s) of Injury(ies)/Illness(es)

Date of Incident dd mm yyyy

F. Return To Work Information - Must be completed by a Health Professional

When work injury/illness occurs, focus on return to usual activity including return to safe and appropriate work is best practice. Most workers who experience soft tissue injury are able to remain at work.

1. Have you discussed return to work with your patient? ☑ yes ☐ no

2. ☐ **This worker can resume Regular duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

☐ **This worker can begin Modified duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

☐ **This worker is not able to work because of the workplace injury/illness.**

Please provide explanation _____

3. Please indicate the worker's status and functional abilities in relation to the workplace injury and diagnosis.

A. Full Functional Abilities ☐

B. Worker Functional Abilities

	Able to	Not Able to		Able to	Not Able to		Able to	Not Able to
Bend/Twist	☐	☐	Operate Heavy Equipment	☐	☐	Stand	☐	☐
Climb	☐	☐	Operate a Motor Vehicle	☐	☐	Use of Public Transportation	☐	☐
Kneel	☐	☐	Push/Pull	☐	☐	Use of Upper Extremities	☐	☐
Lift	☐	☐	Sit	☐	☐	Walk	☐	☐

C. Other Limitations: eg. Environmental Conditions, Medication, Use of Protective Equipment.

Please describe: _____

4. From the date of this assessment, the above limitations will apply for approximately:

☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Follow-up Appointment

☐ None required ☐ As Needed Date of next appointment dd mm yyyy

Health Professional's Name (Please print)	Address 459 Hume St, Collingwood, ON L9Y 1W9	
Health Professional's Signature	Telephone 705-444-8606	Service Date dd mm yyyy 30/05/2021

G. Worker's Signature

By signing below I am authorizing the above noted health professional, who is treating me, to provide my employer with a copy of this page outlining my functional abilities. I understand a copy will be sent to the Workplace Safety and Insurance Board (WSIB) by my health professional.

Signature	Date dd mm yyyy 30/05/2021

Once completed, please ensure that a copy of this page only is provided to the worker.