wsib cspaat ONTARIO

Mail to:
200 Front Street West
Toronto ON M5V 3J1

Or Fax to:
416-344-4684
OR 1-888-313-7373

Acute Low Back injuries Program of Care Initial Assessment Report

Claim Number

Please PRINT in black ink.

A. Patient & Employer Information

Last Name	First Name	Init.

Address (no. street, apt.)

City/Town	Prov.	Postal Code	Telephone

Date of Birth (dd mm yyyy)	Date of Injury (dd mm yyyy)	Sex ☐ F ☐ M

Employer Name	Supervisor/Contact Name	Telephone

Address (no. street, apt.)

City/Town	Prov.	Postal Code

Patient's Current Job Title/Occupation	Length of time in current job: months years

Patient's employment status at time of assessment:

A. ☐ Full time OR ☐ Part time worker
B. ☐ Regular duties OR ☐ Modified duties
C. ☐ Regular hours OR ☐ Modified hours
D. ☐ Not working

Please ask the patient before assessment:
If not working how long do you think you will be off work?

_______ days

B. Health Professional Information

☐ Chiropractor ☐ Physiotherapist ☐ Other ____________

Health Professional Name (please print)	WSIB Provider ID.

Facility Name

Address (no. street, apt.)

City/Town	Prov.	Postal Code	Telephone

C. Clinical Information

1. Indicate the provider/facility who provided first treatment:

Date of First Treatment (dd mm yyyy)

2. Name of referring health professional (if applicable):

Date of Referral (dd mm yyyy)

3. Patient's history of injury:

4. Describe patient's current symptoms:

5. Diagnosis/working diagnosis.

For WSIB use only ICD 9 Code(s)

Patient's Last Name	First Name
Date of Birth (dd mm yyyy)	Date of Injury (dd mm yyyy)

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C. Clinical Information (continued)

6. Summary of physical findings (including pertinent negative findings):

7. Are there any complicating factors that may delay recovery? ☐ Yes ☐ No

If **Yes,** please identify:

☐ Believes hurt equals harm ☐ Low mood/social withdrawal ☐ Home environment concerns ☐ Other: ________

☐ Fears/avoids activity ☐ Prefers passive treatments ☐ Work environment concerns

8. Describe relevant medical information (include medical history, medications, medical conditions, surgeries):

9. Administer and record Numeric Pain Rating Score at initial assessment: ______ /10 (e.g. no pain =0 worst possible pain =10)

10. Indicate Range of Pain:

☐ No low back pain ☐ Low back pain without radiation ☐ Low back pain radiating no further than the knee ☐ Low back pain radiating below the knee, no neurological signs ☐ Low back pain radiating to a precise dermatome, with or without neurological signs

11. Administer and record patient's Roland - Morris Disability Questionnaire score at initial assessment: ______ /24

12. Describe patient's limitations in Activities of Daily Living and/or significant changes (self-care, sleep history, participation and leisure, sports, and hobbies):

D. Treatment Plan & Return To Work Recommendation

13. Specify anticipated treatment plan (include type of intervention, intensity, frequency, duration):

Anticipate treatment beyond 4 weeks (Phase 2)? ☐ Yes ☐ No

14. Are you recommending referral(s) to other health professional(s)? ☐ Yes ☐ No

If **Yes,** provide name and contact information: ________

15. Considering your assessment findings, can patient remain/return to work? ☐ Yes ☐ No

If **Yes,** specify: ☐ Regular duties ☐ Modified duties ☐ Regular hours ☐ Modified hours

If **No,** indicate expected return to work: dd mm yyyy

16. Describe the patient's functional limitations:

A. ☐ No Limitations

B. ☐ Limitations (please specify) ☐ Lifting ☐ Sitting ☐ Climbing stairs/ladders ☐ Kneeling ☐ Standing ☐ Use of upper extremities ☐ Bending/twisting ☐ Other: ________

Comments: ________

It is an offense to knowingly make a false or misleading statement or representation to the Workplace Safety and Insurance Board (WSIB). I hereby declare that the information being submitted is true and complete.

Health Professional's Signature	Date (dd mm yyyy)