Health Professional's Report (Form 8)

For

Chiropractors Physicians Physiotherapists Registered Nurses (Extended Class)

Health Professionals, please use this form when:

- Your patient states that an injury/illness is related to his or her work.
- You believe that the cause of your patient's injury/illness is due to workplace factors.

Section 37 of the *Workplace Safety and Insurance Act, 1997* provides the legal authority for health professionals, hospitals and health facilities to submit, without consent, information relating to a worker claiming benefits to the Workplace Safety and Insurance Board (WSIB).

Your promptness in completing this form is key to our ability to process and adjudicate your patient's claim. Your patient, their employer and the WSIB depend on you.

When completing this report, please **print** using **black pen**.

Your patient should complete Section A of this report. If your patient needs assistance, please help. Please submit this report even if Section A is not fully completed.

Information for completing this report can be found on **Page 4**. For more details, refer to "Guidelines for Health Professionals – Completing WSIB Forms".

Please separate and send **Pages 2 and 3** to the Workplace Safety and Insurance Board:

By Fax to:

416-344-4684 or 1-888-313-7373

Or by Mail to:

Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

WSIB ONTARIO Workplace Safety & Insurance Board
CSPAAT Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

www.wsib.on.ca

WSIB ONTARIO CSPAAT

Health Professional's Report (Form 8)

start

Claim Number (If known)

8

print reset

A. Patient and Employer Information (Patient May Complete Section A)

Last Name	First Name	Init.

Address (no., street, apt.)

City/Town	Prov.	Postal Code	Telephone

Social Insurance No.	Date of Birth dd mm yyyy	Sex ☐ M ☐ F	Language ☐ Eng. ☐ Fr.

Business or Company Name

Address (no., street, apt.)

City/Town	Prov.	Postal Code	Telephone

Is this the first visit to a health professional for this injury? ☐ yes ☐ no ☐ unknown

The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the *Workplace Safety and Insurance Act*. The Social Insurance Number is used to register claims, 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. Health Professional Billing Information

☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class)

Service Code **8**

Health Professional Name (please print)

WSIB Provider ID.

Address (no. street, apt.)

Service Date dd mm yyyy

City/Town	Prov.	Postal Code	Telephone

Your Invoice No.

C. Incident Dates and Details Section

1. What is your understanding as to how this injury/illness or re-injury occurred?

Date of Accident/or when did the symptoms start? dd mm yyyy

2. For this injury, are you this patient's primary Health Professional? ☐ yes ☐ no

Location of this assessment ☐ Office ☐ Emergency Dept. ☐ Workplace ☐ Walk-in Clinic ☐ Other

D. Clinical Information Section

1. Area of Injury (Body Part)- (Please check all that apply)

☐ Brain ☐ Head ☐ Face ☐ Eyes ☐ Ears ☐ Teeth ☐ Neck ☐ Chest ☐ Upper back ☐ Lower back ☐ Abdomen ☐ Pelvis

☐ Other:

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- (Please check all that apply)

☐ Abrasion ☐ Amputation ☐ Avulsion ☐ Bite ☐ Burn ☐ Contusion/Hematoma ☐ Crush Injury ☐ Degenerative Joint Disease ☐ Disc Herniation ☐ Dislocation ☐ Epicondylitis ☐ Fracture ☐ Ganglion ☐ Hernia ☐ Laceration ☐ Puncture

Musculoskeletal

☐ Repetitive Strain Injury ☐ Sciatica ☐ Spinal Cord Injury ☐ Sprain/Strain ☐ Tendonitis/Tenosynovitis

Exposure/Other

☐ Asthma ☐ Dermatitis ☐ Fumes - Inhalation ☐ Hearing Loss ☐ Infectious Disease ☐ Needle Stick ☐ Poisoning/Toxic Effects ☐ Psychological

☐ Other

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Claim Number (If known)

8

Patient's Last Name | Patient's First Name | Date of Birth dd mm yyyy

D. Clinical Information Section (continued)

start

3. Patient's Present Complaints - subjective complaints (Please check all that apply)

☐ Pain ☐ Paresthesia ☐ Stiffness ☐ Swelling ☐ Weakness ☐ Other _____

Additional details (if applicable)

4. Physical Examination - objective findings (Please check all that apply)

☐ Bruising ☐ Crepitation ☐ Joint Dysfunction ☐ Laceration ☐ Tenderness ☐ Other _____

☐ Burns ☐ Deformity ☐ Joint Effusion ☐ Lump/Swelling ☐ Wasting

Additional details (if applicable)

5. Are there abnormal signs for any of the following? (Please check all that apply)

☐ Active ROM ☐ Passive ROM ☐ Gait ☐ Strength ☐ Reflexes ☐ Sensation ☐ Other _____

If so please describe:

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

Additional details (if applicable)

7. Diagnosis/Working Diagnosis

E. Treatment Plan and Return to Work Information

1. Provide your treatment and management plan for this patient. Outline goals, duration, frequency, medication(s) prescribed (including any adverse effects) and any assistive devices (crutches, orthotics, etc.,) if required.

2. Investigations & Referrals:

☐ None ☐ Labs ☐ X-rays ☐ CT Scan ☐ MRI ☐ EMG/NCS ☐ Other _____

☐ Family GP ☐ Chiropractor ☐ Massage Therapist ☐ Occupational Health Centre

☐ Specialist ☐ Physiotherapist ☐ Occupational Therapist ☐ Other: _____

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

3. Please indicate the patient's status and task limitations in relation to the diagnosis (please see Page 4 for special instructions)

A. ☐ **No Limitations**

B. ☐ **Limitations** (as specified)

C. ☐ **Other** (Explanation Required)

- ☐ Standing
- ☐ Sitting
- ☐ Lifting
- ☐ Bending/Twisting
- ☐ Kneeling
- ☐ Climbing Stairs/Ladders
- ☐ Use of Upper Extremities
- ☐ Operating Heavy Equipment
- ☐ Limitations Due To Environmental Conditions
- ☐ Personal Protective Equipment
- ☐ Use of Public Transportation
- ☐ Operation of a Motor Vehicle
- ☐ Medication
- ☐ Other _____

Explanation/Additional details:

4. From the date of this assessment, the above status(es) will apply for approximately:

☐ 1 to 2 days; ☐ 3 to 7 days; ☐ 8 to 14 days; ☐ 14+ days

5. Have you discussed Return To Work and these task limitations as part of your treatment with your patient? ☐ yes ☐ no

6. Follow-up Appointment ☐ None Required; ☐ Next Day; ☐ 2 to 3 days; ☐ 1 week; ☐ 2 weeks

It is an offence to knowingly make a false or misleading statement or representation to the WSIB. I hereby declare that the information being submitted is true and complete.

Health Professional's Signature | Date dd mm yyyy

Please print form & sign before returning to the WSIB

Health Professional's Report (Form 8)
Guidelines for Completion

The following information provides some assistance in completing the Form 8. For additional details please see "Guidelines for Health Professionals – Completing WSIB Forms".

Section A - Patient and Employer Information (Patient to complete this section)

- The information in this section helps to register and administer the patient's claim. It also ensures that the Health Professional's report is sent to the correct claim file. If a patient is unable to complete this section, the Health Professional can assist.

- The patient's personal information is collected under the authority of *The Workplace Safety and Insurance Act* and is used to administer the claim. For more information contact the WSIB Privacy Office toll-free at 1-800-387-5540, ext. 5323 or (416) 344-5323.

- If the patient is unable to supply the SIN number, or other information, the form should still be completed and submitted to the WSIB.

Sections B, C, D and E (to be completed by the Health Professional)

Section D – Clinical Information Section

Please check (✓) all that apply. Include all relevant clinical and/or objective findings or symptoms. Space has been provided for any additional findings/symptoms not listed, or for any other details.

Section E – Treatment Plan & Return to Work Information

Special Instructions:

You are invited to discuss case assessment options with a WSIB medical consultant to assist this worker with a successful return to work. Please do not hesitate to contact us at 416-344-1000 or toll-free 1-800-387-0750.

If the worker or employer has given you a WSIB Functional Abilities Form (FAF) to complete at the same time as you are filling out the Form 8, you do not need to answer Questions E3 - E4 - E5.

If you are indicating the patient is unable to return to work at this time, please provide an explanation in the space provided with Question E3.

- "Please indicate the patient's status and task limitations in relation to the diagnosis." Always complete this question and check (✓) all that apply:

  A. "*No limitations*": Patient is able to return to work now; no task limitations needed.

  B. "*Specified Limitations (Please Specify)* ": Please check all limitations that apply (e.g. standing, sitting, lifting). If you wish to provide further details, please use the space provided.

  C. "*Other (Explanation Required)*": If the patient is unable to return to work in any capacity, the WSIB needs to know why in order to make a determination on entitlement to benefits. Use the space provided to give us this information.

- Please note: You can check more than one status or time period if needed and give an explanation in the space provided e.g., - No return to work for 1 - 2 days, then a return to work with a lifting limitation for 3 - 7 days.

- "*From the date of this assessment, the above status(es) will apply for approximately:* " Check (✓) the time period. Please note that for anything beyond 14 days, the WSIB will request a Progress Report.

This Health Professionals Report (Form 8) is not intended to replace the

WSIB - Functional Abilities Form (FAF) - form 2647A.