Health Professional's Report (Form 8)

Health Professional, please use this form for:

- Patients who are claiming benefits under the WSIB insurance plan for an injury/illness related to work, or
- You think that the cause of your patient's injury/illness is 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).

Completing the form:

- **Give a copy of page two only to your patient to give to employer.**
- **Please send pages one and two to the Workplace Safety and Insurance Board.**
- **On the worker's initial visit, ONLY the Form 8 will be paid. A Functional Abilities Form (FAF) will not be paid if completed on the same date.**

For Electronic Submission

To register for electronic form submission and electronic billing, please go to www.telushealth.com/wsib or call Telus at 1-866-240-7492 for more information.

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

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ONTARIO

www.wsib.on.ca

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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
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 1-800-387-0750.

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	☐	☐
Wrist	☐	☐
Hand	☐	☐
Fingers	☐	☐
Hip	☐	☐
Thigh	☐	☐
Knee	☐	☐
Lower Leg	☐	☐
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 **ONHST** | Your Invoice No. | Service Date dd mm yyyy

Health Professional Name (please print) | Address

Telephone | 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	
Health Professional's Signature	Telephone	Service Date dd mm yyyy

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

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