

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

|                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |               |            |                                                                                                       |                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------|------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| Last Name                                                                                                                                                                                                                                                                                                                                                                                                       |                      | First Name    |            | Init.                                                                                                 | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Address (no., street, apt.)                                                                                                                                                                                                                                                                                                                                                                                     |                      | City/Town     |            | Prov.                                                                                                 | Postal Code                                                  |
| Telephone                                                                                                                                                                                                                                                                                                                                                                                                       | Social Insurance No. | Date of Birth | dd mm yyyy | Language<br><input type="checkbox"/> Eng. <input type="checkbox"/> Fr. <input type="checkbox"/> Other |                                                              |
| Employer Name                                                                                                                                                                                                                                                                                                                                                                                                   |                      |               |            |                                                                                                       |                                                              |
| <p>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.</p> |                      |               |            |                                                                                                       |                                                              |

**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**

|                                       |                                |                                     |                                        |                                |                                     |                                |                                    |                                |                                     |                                |
|---------------------------------------|--------------------------------|-------------------------------------|----------------------------------------|--------------------------------|-------------------------------------|--------------------------------|------------------------------------|--------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Brain        | <input type="checkbox"/> Ears  | <input type="checkbox"/> Upper back | Left <input type="checkbox"/> Shoulder | Right <input type="checkbox"/> | Left <input type="checkbox"/> Wrist | Right <input type="checkbox"/> | Left <input type="checkbox"/> Hip  | Right <input type="checkbox"/> | Left <input type="checkbox"/> Ankle | Right <input type="checkbox"/> |
| <input type="checkbox"/> Head         | <input type="checkbox"/> Teeth | <input type="checkbox"/> Lower back | <input type="checkbox"/> Arm           | <input type="checkbox"/>       | <input type="checkbox"/> Hand       | <input type="checkbox"/>       | <input type="checkbox"/> Thigh     | <input type="checkbox"/>       | <input type="checkbox"/> Foot       | <input type="checkbox"/>       |
| <input type="checkbox"/> Face         | <input type="checkbox"/> Neck  | <input type="checkbox"/> Abdomen    | <input type="checkbox"/> Elbow         | <input type="checkbox"/>       | <input type="checkbox"/> Fingers    | <input type="checkbox"/>       | <input type="checkbox"/> Knee      | <input type="checkbox"/>       | <input type="checkbox"/> Toes       | <input type="checkbox"/>       |
| <input type="checkbox"/> Eyes         | <input type="checkbox"/> Chest | <input type="checkbox"/> Pelvis     | <input type="checkbox"/> Forearm       | <input type="checkbox"/>       | <input type="checkbox"/>            | <input type="checkbox"/>       | <input type="checkbox"/> Lower Leg | <input type="checkbox"/>       | <input type="checkbox"/>            | <input type="checkbox"/>       |
| <input type="checkbox"/> Other: _____ |                                |                                     |                                        |                                |                                     |                                |                                    |                                |                                     |                                |

**2. Description of Injury/Illness Physical Examination Findings**

|                                                      |                                             |                                                     |
|------------------------------------------------------|---------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Pain at rest/Night Pain     | Pain Rating Scale<br>0 1 2 3 4 5 6 7 8 9 10 |                                                     |
| <input type="checkbox"/> Abrasion                    | <input type="checkbox"/> Disc Herniation    | <input type="checkbox"/> Inflammation               |
| <input type="checkbox"/> Amputation                  | <input type="checkbox"/> Dislocation        | <input type="checkbox"/> Internal Joint Derangement |
| <input type="checkbox"/> Bite                        | <input type="checkbox"/> Fall from Height   | <input type="checkbox"/> Joint Effusion             |
| <input type="checkbox"/> Burn                        | <input type="checkbox"/> Foreign Body       | <input type="checkbox"/> Laceration                 |
| <input type="checkbox"/> Contusion/Hematoma/Swelling | <input type="checkbox"/> Fracture           | <input type="checkbox"/> Neurological Dysfunction   |
| <input type="checkbox"/> Crush Injury                | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Psychological              |
|                                                      | <input type="checkbox"/> Infection          | <input type="checkbox"/> Puncture (non-needlestick) |
| <input type="checkbox"/> Other _____                 |                                             |                                                     |

**Pain Rating Scale**

**Exposure/Illness**

|                                                  |
|--------------------------------------------------|
| <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Fumes - Inhalation      |
| <input type="checkbox"/> Hand-arm Vibration      |
| <input type="checkbox"/> Hearing Loss            |
| <input type="checkbox"/> Infectious Disease      |
| <input type="checkbox"/> Needle Stick            |
| <input type="checkbox"/> Poisoning/Toxic Effects |
| <input type="checkbox"/> 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:**

|                                                |                                                     |                                          |                                                           |                              |                              |                                     |                                      |
|------------------------------------------------|-----------------------------------------------------|------------------------------------------|-----------------------------------------------------------|------------------------------|------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> None                  | <input type="checkbox"/> Labs                       | <input type="checkbox"/> Xrays           | <input type="checkbox"/> CT Scan                          | <input type="checkbox"/> MRI | <input type="checkbox"/> EMG | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> FP/GP                 | <input type="checkbox"/> Occupational Health Centre | <input type="checkbox"/> Physiotherapist | Would the patient benefit from the following referrals?   |                              |                              |                                     |                                      |
| <input type="checkbox"/> Specialist/ Specialty | <input type="checkbox"/> Occupational Therapist     | <input type="checkbox"/> Psychologist    | <input type="checkbox"/> Specialty Clinic                 |                              |                              |                                     |                                      |
| <input type="checkbox"/> Chiropractor          | <input type="checkbox"/> Other _____                |                                          | <input type="checkbox"/> Regional Evaluation Centre (REC) |                              |                              |                                     |                                      |
| Name of Referral or Facility (if known)        |                                                     |                                          | Telephone                                                 |                              | Appointment Date dd mm yyyy  |                                     |                                      |

**E. Billing Section**

|                                                                                                                                                                                                                 |                                                      |                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------|
| Health Professional Designation<br><input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Registered Nurse (Extended Class) | Service Code<br><b>8M</b>                            | WSIB Provider ID |
| HST Registration No.                                                                                                                                                                                            | HST Amount Billed (if applicable)<br><b>\$ ONHST</b> | Your Invoice No. |
| Health Professional Name (please print)                                                                                                                                                                         | Address                                              |                  |
| Telephone                                                                                                                                                                                                       | Fax                                                  |                  |

**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) |            |       |            |    |    |      |

|                         |    |    |      |
|-------------------------|----|----|------|
| <b>Date of Incident</b> | 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 | <input type="checkbox"/> | <input type="checkbox"/> | Operate Heavy Equipment | <input type="checkbox"/> | <input type="checkbox"/> | Stand                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb      | <input type="checkbox"/> | <input type="checkbox"/> | Operate a Motor Vehicle | <input type="checkbox"/> | <input type="checkbox"/> | Use of Public Transportation | <input type="checkbox"/> | <input type="checkbox"/> |
| Kneel      | <input type="checkbox"/> | <input type="checkbox"/> | Push/Pull               | <input type="checkbox"/> | <input type="checkbox"/> | Use of Upper Extremities     | <input type="checkbox"/> | <input type="checkbox"/> |
| Lift       | <input type="checkbox"/> | <input type="checkbox"/> | Sit                     | <input type="checkbox"/> | <input type="checkbox"/> | Walk                         | <input type="checkbox"/> | <input type="checkbox"/> |

**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 | <table border="1"><tr><td>dd</td><td>mm</td><td>yyyy</td></tr></table> | dd | mm | yyyy |
| 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.**

## 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](http://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



[www.wsib.on.ca](http://www.wsib.on.ca)