

Health Professional's Report (Form 8)

Health Professional, please use this form for your patients who are claiming benefits under the WSIB insurance plan for an injury/illness:

- Related to his or her 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).

- 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.

Your promptness in completing this form is key to our ability to process and adjudicate your patient's claim.

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

Your patient should complete or assist you in completing Section A of this report. Please submit this report even if Section A is not fully completed.

Page three of this form provides return to work information. Please provide page three to the patient to provide to his or her employer.

Please ensure Section F is completed on the copy given to the patient.

For Electronic Submission

Please **print/save** a copy of the electronic Form 8 for your records. Please also print and provide a copy of **only page three** to the worker.

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.

For Paper Submission

Please send **pages two and three** to the Workplace Safety and Insurance Board and provide a copy of **only page three** to the worker.

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

| | | |
|---|--------------|-------------------|
| Service Code | 8M | |
| ▼ Complete these fields if HST applies to this form ▼ | | |
| HST Registration No. | Service Code | HST Amount Billed |
| ONHST \$ | | |
| WSIB Provider ID | | |
| Service Date (dd/mm/yyyy) | | |
| Your Invoice No. | | |
| Health Professional Name (please print) | | |
| Address | | |

A. Patient and Employer Information - (Patient To Complete Section A)

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

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

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

| | | | |
|--|--|--|---|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Disc Herniation | <input type="checkbox"/> Internal Joint Derangement | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Joint Effusion | <input type="checkbox"/> Sprain/Strain |
| <input type="checkbox"/> Bite | <input type="checkbox"/> Fall from Height | <input type="checkbox"/> Laceration | <input type="checkbox"/> Surgical Intervention |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Foreign Body | <input type="checkbox"/> Neurological Dysfunction | <input type="checkbox"/> Tendonitis/Tenosynovitis |
| <input type="checkbox"/> Contusion/Hematoma/Swelling | <input type="checkbox"/> Fracture | <input type="checkbox"/> Psychological | <input type="checkbox"/> Tumour |
| <input type="checkbox"/> Crush Injury | <input type="checkbox"/> Hernia | <input type="checkbox"/> Puncture | <input type="checkbox"/> Range of Motion |
| | <input type="checkbox"/> Infection | <input type="checkbox"/> Repetitive Strain Injury | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Inflammation | | |

Exposure/Other

| |
|--|
| <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Dermatitis |
| <input type="checkbox"/> Fumes - Inhalation |
| <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Needle Stick |
| <input type="checkbox"/> Poisoning/Toxic Effects |

3. Are you aware of any pre-existing or other conditions/factors that may impact recovery?

Additional details (if applicable) yes no

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 |
|---------------------------------|------|-----------|----------|
| 1. | | | |
| 2. | | | |

| Work Injury/Illness Medications | Dose | Frequency | Duration |
|---------------------------------|------|-----------|----------|
| 3. | | | |
| 4. | | | |

3. Investigations & Referrals:

None Labs Xrays CT Scan MRI EMG Ultrasound Other _____

FP/GP Occupational Health Centre Physiotherapist

Specialist Occupational Therapist Psychologist

Chiropractor Other _____

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) _____

Health Professional's Designation
 Chiropractor Physician Physiotherapist Registered Nurse (Extended Class) Other

| | | | | | | |
|-----------|------------|-------|------------|----|----|------|
| Last Name | First Name | Init. | Birth Date | dd | mm | yyyy |
|-----------|------------|-------|------------|----|----|------|

| | | | |
|----------------------------|----|----|------|
| 1. Date of Incident | dd | mm | yyyy |
|----------------------------|----|----|------|

E. 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.

2. Have you discussed return to work with your patient? yes no

3. This worker can resume his Regular duties yes no Start Date

| | | |
|----|----|------|
| dd | mm | yyyy |
|----|----|------|

OR
This worker can resume his Modified duties yes no Start Date

| | | |
|----|----|------|
| dd | mm | yyyy |
|----|----|------|

4. Please indicate the worker's status and task limitations in relation to the workplace injury and diagnosis.

A. **No Limitations**

B. **Some Limitations** (as specified)

| | | |
|--|--|---|
| <input type="checkbox"/> Bending/Twisting | <input type="checkbox"/> Medication | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Operating Heavy Equipment | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Operation of a Motor Vehicle | <input type="checkbox"/> Use of Public Transportation |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Personal Protective Equipment | <input type="checkbox"/> Use of Upper Extremities |
| <input type="checkbox"/> Limitations Due to Environmental Conditions | <input type="checkbox"/> Pushing/Pulling | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Other _____ | | |

C. **Other**
Explanation Required - if worker is not able to work because of the workplace injury/illness please provide details.

| | | | | |
|---|---|------|----|------|
| 5. From the date of this assessment, the above will apply for approximately: | 6. Follow-up Appointment | | | |
| <input type="checkbox"/> 1 - 2 days <input type="checkbox"/> 3 - 7 days <input type="checkbox"/> 8 - 14 days <input type="checkbox"/> 14 + days | <input type="checkbox"/> None Required Date of Next Appointment <table style="display: inline-table; border: 1px solid black;"><tr><td style="width: 20px;">dd</td><td style="width: 20px;">mm</td><td style="width: 20px;">yyyy</td></tr></table> <input type="checkbox"/> As Needed | dd | mm | yyyy |
| dd | mm | yyyy | | |

| | | | | |
|---|---|------|----|------|
| Health Professional's Name (Please print) | Service Date <table style="display: inline-table; border: 1px solid black;"><tr><td style="width: 20px;">dd</td><td style="width: 20px;">mm</td><td style="width: 20px;">yyyy</td></tr></table> | dd | mm | yyyy |
| dd | mm | yyyy | | |
| Health Professional's Signature | Telephone | | | |

F. 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 <table style="display: inline-table; border: 1px solid black;"><tr><td style="width: 20px;">dd</td><td style="width: 20px;">mm</td><td style="width: 20px;">yyyy</td></tr></table> | dd | mm | yyyy |
| dd | mm | yyyy | | |

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Paper Submission : Please send **pages two and three** to the Workplace Safety and Insurance Board and provide a copy of **only page three** to the worker.

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.

Employers : Health professionals will be supplying your employee with a copy of page three of the Form 8. This is for your use in return to work planning. Please do not send your copy to WSIB.