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.

...go to form

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

wsib cspaat ONTARIO

www.wsib.on.ca

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print reset save

wsib cspaat ONTARIO

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

OR Fax To: 416-344-4684 OR 1-888-313-7373

Claim Number (If known) *Start >*

8 Health Professional's Report (Form 8)

Service Code **8M**

▼ Complete these fields if HST applies to thls form ▼

HST Registration No. | Service Code **ONHST** | HST Amount Billed **$**

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. **ON** | Postal Code | Telephone | Language ☐ Eng. ☐ Fr. ☐ Other

Social Insurance No. | Date of Birth dd mm yyyy | Sex ☐ M ☐ 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

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

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/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 ☐ Repetitive Strain Injury
☐ Spinal Cord Injury ☐ Sprain/Strain ☐ **Surgical Intervention** ☐ Tendonitis/Tenosynovitis ☐ Tumour ☐ Range of Motion ☐ Other

Exposure/Other

☐ Asthma ☐ Dermatitis ☐ Fumes - Inhalation ☐ Hearing Loss ☐ Infectious Disease ☐ Needle Stick ☐ 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	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 ☐ 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

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

wsib cspaat ONTARIO

Claim Number (If known)

8

Health Professional's Report (Form 8)

Last Name	First Name	Init.	Birth Date dd mm yyyy

Start >

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 or her Regular duties ☐ yes ☐ no Start Date dd mm yyyy

OR

This worker can resume his or her 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)

- ☐ Bending/Twisting
- ☐ Climbing
- ☐ Kneeling
- ☐ Lifting
- ☐ Limitations Due to Environmental Conditions
- ☐ Medication
- ☐ Operating Heavy Equipment
- ☐ Operation of a Motor Vehicle
- ☐ Personal Protective Equipment
- ☐ Pushing/Pulling
- ☐ Sitting
- ☐ Standing
- ☐ Use of Public Transportation
- ☐ Use of Upper Extremities
- ☐ Walking
- ☐ 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:

☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

6. Follow-up Appointment

☐ None Required
☐ As Needed

Date of Next Appointment dd mm yyyy

Health Professional's Name (Please print)	Service Date dd mm yyyy
Health Professional's Signature	Telephone

Please print form & sign before returning to the WSIB or giving a copy to the worker

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 dd mm yyyy
Please print form to sign.	

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.

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.

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