wsib ONTARIO

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

26 Health Professional's Progress Report (Form 26)

Section 37 of the Workplace Safety and Insurance Act authorizes you to release this information to the WSIB. Please answer all questions in black ink or type and return by fax to (416) 344-4684 or 1-888-313-7373.

Claim Number

Worker's name	Date of Incident (dd/mmm/yyyy)

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.

Return to Work Information

1. ☐ This worker can resume Regular duties. Start date (dd/mmm/yyyy) ____ Are graduated hours required? If yes, please specify ____

☐ This worker can begin Modified duties. Start date (dd/mmm/yyyy) ____ Are graduated hours required? If yes, please specify ____

☐ Pain should not be the only medical restriction. Is there any other reason this worker cannot return to work at this time?
Please provide details and expected return to work date:

2. Please indicate the worker's functional abilities in relation to the workplace injury.

A. Full functional abilities ☐

B. Some functional abilities

	Able to	Not Able to		Able to	Not Able to
Bend/Twist	☐	☐	Push/Pull	☐	☐
Climb	☐	☐	Sit	☐	☐
Kneel	☐	☐	Stand	☐	☐
Lift	☐	☐	Use of Public Transportation	☐	☐
Operate Heavy Equipment	☐	☐	Use of Upper Extremities	☐	☐
Operate a Motor Vehicle	☐	☐	Walk	☐	☐

Other Limitations due to: ☐ Environmental Conditions ☐ Medication ☐ Use of Protective Equipment

Additional comments on abilities (e.g. maximum repetitions, maximum weight, maximum time to be considered).

Clinical Information and Treatment Plan

3. Please indicate change in the patient's condition since last visit. ☐ Recovered ☐ Improving ☐ Worsening ☐ Unchanged
If worsening, provide details on the patient's condition:

4. Current diagnosis.

5. Are you aware of any pre-existing or other conditions/factors that would impact return to work or recovery? ☐ Yes ☐ No
If Yes, describe (e.g. psychosocial, medications).

6. Prognosis - Please select one of the following choices:

☐ Fully recovered now.

☐ Partially recovered now and full recovery is anticipated in approximately ____ weeks.

☐ Partially recovered now, continuing to improve. Full recovery not yet known.

☐ Full recovery not expected.

7. What is the current treatment plan (type of treatment, interventions, duration)?

Billing Section

Health Professional Designation ☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) | Service Code | WSIB Provider ID

HST Registration No.	HST Amount Billed (if applicable)	Service Code	Your Invoice No.	Service Date dd mmm yyyy
	$	ONHST		

Health Professional Name (please print)	Address	
Health Professional's Signature	Telephone	Fax