WSIB ONTARIO CSPAAT

NIHL Assessment Summary & Treatment Plan Form

To avoid delays, please complete in full printing in black ink.

Claim Number (If known)

A. Patient & Employer Information Section (Patient to Complete this Section)

Last Name | First Name | Init.

Address (no. street, apt.)

City/Town | Prov. | Postal Code | Telephone No. ( )

Date of Birth dd mm yy | Date of Accident dd mm yy | Date of Assessment dd mm yy | Sex ☐ M ☐ F

If return to work is considered, has the employer been contacted? ☐ yes ☐ no

Employer Name | Supervisor/Contact Name

Address (no. street, apt.)

City/Town | Prov. | Postal Code | Telephone No. ( )

B. Health Professional/Service Provider Billing Information

Health Professional/Service Provider Name (please print) | WSIB Provider ID.

Facility | Your Invoice No.

Address (no. street, apt.)

City/Town

Prov. | Postal Code | Fax No. ( ) | Telephone No. ( ) | Extension | Service Code **NIHL01**

C. Audiometric Assessment (include Audiogram)

SRT R ☐ dB L ☐ dB | **UCL** R ☐ dB L ☐ dB | **MCL** R ☐ dB L ☐ dB

Has **RECD** been completed ☐ Yes ☐ No

Are red flags present? (see list on page 2) ☐ Yes ☐ No

If yes, please list with Treatment Recommendation:

D. Rehab Needs Assessment (See Booklet For Details)

☐ Education (Explain Details)

☐ Orientation (Explain Details)

☐ Other (Explain Details)