WSIB Community Mental Health Program Assessment Form

Claim number

Visit wsib.ca/submit to submit this form and supporting documents.

A. Worker & Employer Information Section

Last name	First name		Init.
Address (no. street, unit)			
City/Town	Prov.	Postal code	Telephone
Date of Birth (dd/mmm/yyyy)	Date of injury (dd/mmm/yyyy)		
Employer name	Supervisor/contact name		Telephone No.
Worker's current job title/occupation	Approximate length of time in current job: Months Years		

Employment status at time of initial psychological assessment:

☐ Full time **OR** ☐ Part time ☐ Not working
☐ Regular duties **OR** ☐ Modified duties
☐ Regular hours **OR** ☐ Modified hours

Comments

B. Health Professional Information

☐ Psychologist			WSIB Provider ID		
Psychologist's name			Your invoice no.		
Facility name			Date of assessment report (dd/mmm/yyyy)		
Address (no. street, unit)			Service code **MHPIAF**		
City/town			Complete these fields if HST is applicable to this form		
Province	Postal code	Telephone	HST Reg. No.	Service code **ONHST**	HST amount billed $

C. Clinical Information

1. Name and title of referring physician (if available)	2. Date of referral (dd/mmm/yyyy)
3. Initial psychological assessment dates	4. Approximate period/date of onset for psychological symptoms:

5. Behavioural observations

Email accessibility@wsib.on.ca if you need a different format or accommodation. Disponible en français.

Worker's last name	Worker's first name
Date of birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)

C. Clinical Information (continued)

6. Worker's description of injury, including history of events/exposures if relevant

7. Current symptoms

8. Psychological testing completed? ☐ Yes ☐ No

Please provide a brief summary

9. Are you aware of any pre-existing or co-existing psychological conditions, or other relevant/ contributing factors? ☐ Yes ☐ Unknown

If **yes**, please describe briefly (e.g. diagnosis, date of onset, previous treatment if known)

Worker's last name	Worker's first name
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C. Clinical Information (continued)

10. Initial work related DSM diagnosis (please include DSM edition used. For diagnosis of PTSD in First Responders only, please confirm that the patient's presentation meets the diagnostic criteria for DSM5)

11. Impairments in function (social, occupational and other)

D. Psychological Treatment Plan

☐ No psychological treatment required (please proceed to Section E)

☐ Not suitable for this program/requires specialized care (call WSIB)

OR Estimated number of treatment blocked recommended: ☐ 1 block ☐ 2 blocks ☐ 3 blocks

* In all cases, a **Progress Form** is required at the end of every 6th session or 8th week, whichever comes first.

12. Treatment goals

13. Treatment interventions/approaches including frequency (e.g. weekly, biweekly, remote) and other comments

E. Occupational Function Information

In your opinion, is the worker at imminent risk of harm to himself/herself or others? ☐ Yes ☐ No

If yes, please explain including level of risk, and provide plan. Attach a separate page if necessary.

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E. Occupational Function Information (continued)

Have you identified any barriers to return to occupational function? (e.g. harassment, lack of accommodation, etc.) ☐ Yes ☐ No
If **yes**, explain plan

Considering your assessment findings, can the worker remain/return to safe and sustainable occupational function from a psychological perspective? ☐ Yes ☐ No
If **no**, please explain including timeframe

Describe the worker's functional abilities from a psychological perspective:
- ☐ Full abilities
- ☐ Restrictions/limitations/recommended accommodations

Symptoms requiring restrictions/limitations/accommodations	Recommended restrictions/limitations/accommodations

Expected duration

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E. Occupational Function Information (continued)

Would the worker benefit from a Specialty Program assessment and/or other assessment/ treatment/intervention? ☐ Yes ☐ No

If **yes**, describe

Name	Health Professional Signature	Date (dd/mmm/yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.