

Claim Number

Please PRINT in black ink.

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:				
<input type="checkbox"/> Full time OR <input type="checkbox"/> Part time <input type="checkbox"/> Not working <input type="checkbox"/> Regular duties OR <input type="checkbox"/> Modified duties <input type="checkbox"/> Comments: <input type="checkbox"/> Regular hours OR <input type="checkbox"/> Modified hours				

B. Health Professional Information

<input type="checkbox"/> 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:	

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

7. Current symptoms:

8. Psychological testing completed?
 Yes No Please provide 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):

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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 blocks 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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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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Would the worker benefit from a Specialty Program assessment and/or other assessment/treatment/intervention?

Yes No If **yes**, describe:

Health Professional Signature	Date (dd/mmm/yyyy)
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