



Psychology - Initial Assessment Report

Psychologist name: _____ WCB claim number: _____
 Degree: _____ SCP: _____ Date of injury: _____
 Clinic number: _____ Provincial Health number: _____
 Tel: _____ Fax: _____ Date of birth: _____ Tel: _____
 Date of initial session: _____ Employer name: _____
 Clinic name, address and postal code: _____ Injured worker's name, address and postal code: _____

- Use DSM-5 for any diagnostic information, with the exception of GAF (global assessment of functioning) from DSM-IV-TR.
- This form is expected to contain answers to questions and concise statements that clearly address the issues.
- If treatment is occurring in a secondary or tertiary treatment centre, it is to be integrated and sent within the treatment centre.

Has a mental health assessment (MHA) been completed?

Yes No

The mental health assessment findings and recommendations should be discussed at the first session. Any disagreement with the treatment plan must be reported to the Manager, WCB Health Care Services by leaving a message at 306.787.7760.

The following section is not completed if the injured worker has not had an MHA.

Have you discussed the MHA findings with the injured worker?

Yes No MHA not done

Outcome of this discussion:

Do you and the injured worker agree with the MHA findings?

Yes No

Discuss any issues related to MHA per above:



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Have you discussed the RTW recommendations from the MHA with the employer?

Yes

No

If no, why not?

DSM-5 diagnoses from the MHA: _____

GAF from the MHA (global assessment of functioning, DSM-IV-TR) *Provide number and verbal description:*

Anticipated discharge date: _____

CLAIM BACKGROUND

Brief description of injury circumstances

Does the injured worker’s report of injury coincide with the WCB information?

Yes

No (report discrepancies or additional information)

Report discrepancies/additional information

Is the injured worker receiving income replacement?

Yes

No

Other benefits or payments?

Yes (explain below)

No

If yes, what type of benefits or payments (e.g., loan insurance, mortgage insurance, etc.)?

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What prior treatment has been received? *Include any psychology, counselling, medication, debriefing and discuss injured worker's comments about effectiveness.*

Are there physical injuries?

Yes

No

If yes, list them and if they are being treated and response.

List of medications, dosages and why prescribed: *also list injured worker comments as to effectiveness.*

DIAGNOSTIC INFORMATION

- *To be completed if MHA has not been completed. Need not be completed if referral to psychology is post-MHA, but if updated testing is clinically indicated, report it here after approval from WCB Health Care Services in all cases post-MHA.*
- *If the testing is checklists of symptoms, it must be represented as checklists and validity should be reported as "no validity scale results". Such testing may be used to establish a working diagnosis when combined with appropriate interviews.*
- *All diagnoses are subject to adjudicative acceptance.*
- *At the WCB, we define three levels of diagnosis:*
 1. *Reason for visit (RFV)*
 2. *Working diagnosis (WD)*
 3. *Full assessment diagnosis (FAD)*
- *RFV diagnoses are not acceptable on this form. Do not represent Working Diagnoses as Full Assessment Diagnoses. A full assessment diagnosis must be established via MHA or other approved assessment and is subject to WCB adjudication.*

Claim number: _____

Diagnoses: (DSM-5)

Diagnoses: *label clearly as Working Diagnoses or Full Assessment Diagnoses with reference to above.*

Diagnoses considered and ruled out:

List and brief description of tests used: *for well-known tests, a sentence stating what the instrument is, is acceptable, e.g., “[name of test], a multi-dimensional personality inventory containing validity and clinical scales.”; “[name of test], a checklist of symptoms which does not contain validity scales”. If no tests given, state “No tests given” or “Tests given previously”.*

The following 2 headings may be omitted if you have indicated “tests given previously” above.

Validity of psychological testing: *provide interpretations of validity results, including interpretations you have not chosen.*

Clinical results: *Provide interpretations of clinical results, including interpretations you have not chosen. Results must be integrated, e.g., reporting invalidity on one test and validity on a second test is not acceptable practice unless the results are integrated for non-psychologist readers.*

Claim number: _____

Global assessment of functioning (GAF). *To be completed in all cases; provide number/range and description. Indicate if this has changed or is unchanged; if changed, state why.*

WORK AND FUNCTIONAL INFORMATION

Name of employer or business: _____

Employer contact name for RTW: _____

Employer tel: _____

Employer fax: _____

Is the injured worker functional at home and daily tasks?

Yes

No

Describe any functional limitations at home. *Include management of activities of daily living (ADL) and non-work activities, such as shopping, child care, leisure activities.*

What activities of daily living is the injured worker involved in? *Comment on childcare, personal care, shopping, leisure activities, volunteer work, home business, etc.*

Claim number: _____

What specific goals have you set for function at home and daily tasks until the next report?

Is the injured worker to participate in a physical exercise program (applies only to injured workers in tertiary treatment centres only)?

Yes

No

If yes, specify the schedule:

Are there any barriers to physical exercise programming?

Yes

No

If yes, what are the barriers?

Is the injured worker at work?

Yes

No

If yes, are these:

Regular duties

Accommodated duties

List schedule and restrictions if any:

If not at work, is the injured worker ready for full work?

Yes

No

Claim number: _____

If not at work, is the injured worker ready for accommodated work?

 Yes No

If ready for accommodated RTW, list psychological restrictions and limitations: *Be specific, using the WCB List of Restrictions information sheet as a guide. Always avoid stating specific work locations and work positions because these are the employer responsibilities, e.g., it is acceptable to say "the injured worker needs to avoid", but not "the injured worker should work in <name of job position or location>".*

If not at work, have you contacted the employer regarding RTW timelines/plans?

 Yes No

If no, why not? *It is a general expectation that the employer be contacted for discussion of return to work. Such discussions should concern current restrictions and details of employer offers of any alternate duties which accommodate the restrictions.*

Details of the RTW discussion with the employer: *Include projected timeline and any details of progression known.*

Is a workplace visit (live exposure) required?

 Yes No

Details: *Include timeline, what the injured worker requires exposure to, schedule, outcome of discussion of live exposure with employer as known. If the decision is pending about live exposure, state what is required to determine the need.*

Claim number: _____

Have you discussed RTW planning and time frames with the injured worker?

Yes

No

Is the plan accepted:

By injured worker?

Yes

No

By employer?

Yes

No

Details:

TREATMENT

Recommended treatment from MHA or other assessment:

Frequency and duration recommended: _____

Personnel involved: *Only if in a treatment centre. May include clinic staff under the direction of the psychologist.*

Are workplace visits (live exposure) required?

Yes

No

Details: *Include timeline, what the injured worker requires exposure to, schedule, if within a treatment centre what other personnel will assist the psychologist with this, outcome of discussion of live exposure with employer. If the decision is pending about live exposure, state what is required to determine the need.*

Claim number: _____

Are there any external, non-claim issues that may delay recovery?

Yes

No

Details:

Are there any additional risk factors for recovery?

Yes

No

List other issues of clinical relevance not part of claim:

Psychologist's signature: _____ **Date:** _____

Treatment centre therapist's signature: _____ **Date:** _____
(Omit if not in a treatment centre)