Health Professional's Report for Occupational Mental Stress (Form CMS8)

For completion by Physician or Nurse Practitioner only

Regulated Health Professional please use this form for:

- Patients who are claiming benefits under the WSIB insurance plan for occupational mental stress related to work, or
- Situations where you think the cause of your patient's occupational mental stress is work-related.

Please inform the patient that a claim can only be initiated by:

- The patient, who can complete and submit the *Worker's Report of Injury or Disease* - Form 6 or eForm6 or by calling and speaking to a WSIB representative at 1-800-387-0750 or 416-344-1000 (TTY: 1-800-387-0050), OR
- Their employer, who can submit the *Employer's Report of Injury or Disease* - Form 7 or eForm7

Section 37 of the *Workplace Safety and Insurance Act*, *1997* provides the legal authority for health professionals, hospitals and health facilities to submit, without consent, information relating to a worker claiming benefits to the Workplace Safety and Insurance Board (WSIB).

After completing the form:

- **Give a copy of page two only to your patient to give to their employer.**
- **Please send pages one and two to the Workplace Safety and Insurance Board.**

Please note:

- **On the patient's initial visit, ONLY the Form CMS8 will be paid. A Functional Abilities Form (FAF) will not be paid if completed on the same date.**

Fax to:

416-344-4684 or 1-888-313-7373

Or Mail to:
Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

wsib
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ONTARIO

www.wsib.on.ca

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

Claim Number (If known)

Health Professional's Report for Occupational Mental Stress (Form CMS8)

A. Patient and Employer Information (Patient to complete Section A)

Last Name	First Name	Init.	Sex ☐ M ☐ F
Address (number, street, apt.)	City/Town	Prov.	Postal Code
Telephone	Date of Birth dd mm yyyy	Language ☐ English ☐ French ☐ Other	
Employer Name	Supervisor/Contact Name	Telephone	
Employer Address	Patient's Job Title/Occupation		

The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the Workplace Safety and Insurance Act. Questions should be directed to the decision maker responsible for the file or toll free at 1-800-387-0750.

B. General Section

1. Is your patient indicating that their psychological condition is due to work? ☐ yes ☐ no

Date patient first sought medical care for psychological condition dd mm yyyy	Date of onset of symptoms/signs dd mm yyyy
2. Does your patient continue to exhibit the psychological condition? ☐ yes ☐ no	If no, indicate date of last symptoms or when symptoms resolved dd mm yyyy

3. What is your understanding of the work-related situation(s) resulting in the reported psychological condition? Please explain.

C. Clinical Information Section

1. Document the diagnosis and criteria for the DSM diagnosis, if met.

Diagnosis (provide DSM diagnosis if possible):	DSM criteria for the diagnosis, if met:

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

☐ yes ☐ no ☐ unknown

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

D. Treatment Plan

1. What is the treatment plan (including type of treatment, duration, prescribed medications and any recommended referrals)?

E. Billing Section

Health Professional Designation ☐ Physician ☐ Nurse Practitioner ☐ Other _____				Service Code **8CMS**	WSIB Provider ID
HST Registration No.	HST Amount Billed (if applicable) **$**	Service Code **ONHST**	Your Invoice No.	Service Date dd mm yyyy	
Health Professional Name (please print)		Address			
Telephone		Fax			

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Claim Number (If known)

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Once completed, please ensure that a copy of this page only is provided to the patient.

Last Name	First Name	Init.	Date of Birth dd mm yyyy

Date patient first sought medical care for psychological condition dd mm yyyy

F. Return To Work Information - Must be completed by a Health Professional

When work injury/illness occurs, focus on return to usual activity including return to safe and appropriate work is best practice.

1. Has the patient lost time from work as a result of the psychological condition? ☐ yes ☐ no
If no, go to question 4.

2. If the patient is not at work,

A. ☐ **This patient can resume Regular duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

B. ☐ **This patient can begin Modified duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

C. ☐ **This patient is not able to work because of the psychological condition.**
Please provide explanation:

What would need to be in place for your patient to return to work in any capacity? Please list:

3. With respect to your patient's psychological condition, please describe your patient's functional abilities to facilitate work accommodations.

A. ☐ **Full functional abilities, no accommodations required.**

B. ☐ **Patient has impairments in function (social, occupational, other), accommodations are required. Please describe:**

C. ☐ **Other limitations. Please describe:**

4. Your patient's next follow-up appointment
☐ None required ☐ As Needed ☐ Scheduled, please indicate date

Date of next appointment dd mm yyyy

Health Professional's Name (Please print)	Address	
Health Professional's Signature **PLEASE PRINT AND SIGN**	Telephone	Service Date dd mm yyyy

G. Worker's Signature

By signing below I am authorizing the above noted health professional, who is treating me, to provide my employer with a copy of this page outlining my functional abilities. I understand a copy will be sent to the Workplace Safety and Insurance Board (WSIB) by my health professional.

Signature	Date dd mm yyyy
PLEASE PRINT AND SIGN	

Once completed, please ensure that a copy of this page only is provided to the patient.

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