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wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail to:
200 Front Street W.
Toronto ON
M5V 3J1

Fax to:
416-344-4684 or
1-888-313-7373

WSIB Community Mental Health Program Assessment Form

Please PRINT in black ink.

Start > Claim Number

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

Psychologist's Name

Facility Name

Address (no. street, unit)

City/Town

Province | Postal Code | Telephone

WSIB Provider ID

Your invoice no.

Date of assessment report (dd/mmm/yyyy)

Service code **MHPIAF**

Complete these fields if HST is applicable to this form

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:	

Worker's Last Name	Worker's First Name
Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)

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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.

Worker's Last Name	Worker's First Name
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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:

Worker's Last Name	Worker's First Name
Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)

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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 **PLEASE PRINT AND SIGN**	Date (dd/mmm/yyyy)

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