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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 Progress Form

Claim Number

Start >

Please PRINT in black ink.

A. Worker & Employer Information Section

Last Name	First Name	Init.

Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)	Date of initial psychology assessment: (dd/mmm/yyyy)

Treatment Block number : _____

☐ Worker completed Block (6 sessions over up to 8 weeks)

☐ Worker did not return/self-discharged

Number of sessions provided in this block: _____

Treatment Period: _____ to _____

Current employment status:

☐ Full time **OR** ☐ Part time ☐ Not working

☐ Regular duties **OR** ☐ Modified duties Comments:

☐ Regular hours **OR** ☐ Modified hours

B. Health Professional Information

☐ Psychologist

WSIB Provider ID

Psychologist's Name

Your invoice no.

Facility Name

Date of this progress report (dd/mmm/yyyy)

Address (no. street, unit)

Service code **MHPBTF**

City/Town

Complete these fields if HST is applicable to this form

Province	Postal Code	Telephone

HST Reg. No.	Service Code	HST Amount Billed $
	ONHST	

C. Treatment Progress and Response

1. Treatment goals previously identified:

2. Treatment interventions/approaches provided to date:

3. Response to treatment:

☐ No improvement ☐ Minimal improvement ☐ Moderate improvement ☐ Significant improvement ☐ Fully resolved

Please provide details on response to date, expected outcomes and prognosis:

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

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4. Updated DSM diagnosis (please include change in status e.g. resolved, improving, unchanged, worse, new, subthreshold):

5. Functional status (social, occupational, other):

D. Psychology Treatment Plan

☐ No additional treatment recommended at this time. Explain:

OR

☐ Continue treatment (as authorized). Provide additional information:

OR

☐ Additional psychological treatment recommended beyond this program. (Call WSIB)

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
Date of Birth (dd/mmm/yyyy)	Date of Injury (dd/mmm/yyyy)

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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:

Would you like a case file discussion with WSIB staff? ☐ Yes ☐ No

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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