

Claim number

A. Patient information		
Last name	First name	Initials
Date of birth (dd/mmm/yyyy)	Date of injury (dd/mmm/yyyy)	Date of initial psychology assessment: (dd/mmm/yyyy)
Treatment Block number :	Number of sessions provided in this block:	
Patient completed this Block (6 sessions over up to 8 weeks) Patient did not return/self-discharged	Treatment period:	to
Current employment status:		
A. Full time	or Part time	Not working
B. Regular duties	or Modified duties	Comments:
C. Regular hours	or Modified hours	

B. Health professional information		
<input type="checkbox"/> Psychologist	WSIB Provider ID	
Psychologist's name	Your invoice number	
Facility name	Date of this progress report (dd/mmm/yyyy)	
Address (number, street, suite)	Service code MHPBTF	
City/town	Province	Complete these fields if HST is applicable to this form
	HST registration number	Service code ONHST
Postal code	Telephone	HST amount billed

C. Treatment progress and response
1. Treatment Goals - symptom reduction and functional restoration goals, including goals relevant to return to work:
2. Treatment interventions/approaches provided to date:
3. Response to treatment:
Worsening No improvement Minimal improvement Moderate improvement Significant improvement Fully resolved
Please provide details on response to date, expected outcomes and prognosis:

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

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4. Goal Attainment Scaling (G.A.S): Community Mental Health Program treatment is goal directed toward symptom reduction and functional restoration including the restoration of occupational functioning. It is expected the psychologist, together with the patient, will develop and evaluate SMART Goals. The SMART Goals serve to accomplish and evaluate progress towards the patient's treatment goals. SMART goals are Specific, Measurable, Achievable, Relevant, and Time-bound.

Goals (Goals set earlier in the current reporting period)	Goals achieved as expected? (Compare extent goals achieved at end of reporting period to the beginning of the same reporting period)		Goal status
SMART goal # 1	yes	Much better A little better As expected	In progress – continue in next reporting period Goal completed
	no	Partly acheived Much less than expected	Revision required No further gains anticipated
SMART goal # 2	yes	Much better A little better As expected	In progress – continue in next reporting period Goal completed
	no	Partly acheived Much less than expected	Revision required No further gains anticipated
SMART goal # 3	yes	Much better A little better As expected	In progress – continue in next reporting period Goal completed
	no	Partly acheived Much less than expected	Revision required No further gains anticipated
SMART goal # 4	yes	Much better A little better As expected	In progress – continue in next reporting period Goal completed
	no	Partly acheived Much less than expected	Revision required No further gains anticipated

Comment on overall goal attainment, including as related to functional restoration:

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

6. 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 patient 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 patient remain/return to safe and sustainable occupational function from a psychological perspective?

yes no If **no**, please explain including timeframe and next re-evaluation date:

Describe the patient'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 patient benefit from a Specialty Program assessment and/or other assessment/treatment/intervention?

yes no If **yes**, describe:

Psychologist/Psychological associate signature (print, sign and return to the WSIB or type and upload)	Date (dd/mm/yyyy)
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