WSIB Ontario

Community Mental Health Program progress form

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 :

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

☐ Patient did not return/self-discharged

Number of sessions provided in this block:

Treatment period: to

Current employment status:

A. ☐ Full time **or** ☐ Part time ☐ Not working

B. ☐ Regular duties **or** ☐ Modified duties

C. ☐ Regular hours **or** ☐ Modified hours

Comments:

B. Health professional information

☐ 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

Postal code	Telephone

Complete these fields if HST is applicable to this form

HST registration number	Service code **ONHST**

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.

Claim number

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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 ☐ no	☐ Much better ☐ A little better ☐ As expected ☐ Partly achieved ☐ Much less than expected	☐ In progress – continue in next reporting period ☐ Goal completed ☐ Revision required ☐ No further gains anticipated
SMART goal # 2	○ yes ○ no	☐ Much better ☐ A little better ☐ As expected ☐ Partly achieved ☐ Much less than expected	☐ In progress – continue in next reporting period ☐ Goal completed ☐ Revision required ☐ No further gains anticipated
SMART goal # 3	☐ yes ☐ no	☐ Much better ☐ A little better ☐ As expected ☐ Partly achieved ☐ Much less than expected	☐ In progress – continue in next reporting period ☐ Goal completed ☐ Revision required ☐ No further gains anticipated
SMART goal # 4	☐ yes ☐ no	☐ Much better ☐ A little better ☐ As expected ☐ Partly achieved ☐ Much less than expected	☐ In progress – continue in next reporting period ☐ Goal completed ☐ Revision required ☐ No further gains anticipated

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

Patient last name	Patient first name
Date of birth (dd/mmm/yyyy)	Date of injury (dd/mmm/yyyy)

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 submit)	Date (dd/mm/yyyy)