WSIB Ontario

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

To be completed by a physician or nurse practitioner only

Please use this form for:

- patients who are currently claiming benefits through the Workplace Safety and Insurance Board (WSIB) for work-related mental stress injuries
- situations where you think the cause of your patient's mental stress is work-related.

Let the patient know they must visit **wsib.ca/report** to report their mental stress injury to us. Their employer must also visit wsib.ca/report to report it to us.

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 person with an injury or illness claiming benefits to the Workplace Safety and Insurance Board (WSIB).

After completing the form:

- give a copy of page three to your patient to give to their employer
- send a copy of pages two and three to the WSIB:
  - online at **wsib.ca/submit**
  - fax to 416-344-4684 or 1-888-313-7373

On the patient's initial visit, only the Health professional's report for occupational mental stress (form CMS8) will be paid. A Functional abilities form (FAF) will not be paid if completed on the same date.

If you have any questions about this form, call us toll-free at 1-800-387-0750, from 7:30 a.m. to 5 p.m., Monday to Friday.

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Claim number

Visit wsib.ca/submit to submit this form and supporting documents.

A. Patient and employer information (patient to complete section A)

Last name	First name	Initial	Sex ☐ M ☐ F
Address (number, street, apt.)	City/town	Prov.	Postal code
Telephone	Date of birth (dd/mmm/yyyy)	Language ☐ English ☐ French ☐ Other, please specify:	
Employer name	Supervisor/contact came	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*. If you have any questions, contact the decision maker responsible for your claim or call us 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/mmm/yyyy) .....
   Date of onset of symptoms/signs (dd/mmm/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/mmm/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 Diagnostic and Statistical Manual of Mental Disorders (DSM), 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 number	HST amount billed (if applicable)	Service code **ONHST**	Your invoice No.	Service date (dd/mmm/yyyy)
Health professional name	Address		Telephone	Fax

Email accessibility@wsib.on.ca if you need a different format or accommodation. Disponible en français.

WSIB Ontario | wsib.ca

Claim number

Once complete, please give the patient this page only. The patient can give this page to their employer, if needed.

Last name	First name	Init.

Date of birth (dd/mmm/yyyy)	Date patient first sought medical care for psychological condition (dd/mmm/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 four.

2. Choose one of the following if the patient is not currently at work,
   A. ☐ This patient can resume regular duties starting (dd/mmm/yyyy) .....
      If graduated hours required please specify .....
   B. ☐ This patient can begin modified duties starting (dd/mmm/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 the patient's psychological condition, please describe their 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. The patient's next follow-up appointment ☐ None required ☐ As needed ☐ Scheduled, please indicate date	Date of next follow-up appointment (dd/mmm/yyyy)

Health professional's name	Address	
Health professional's signature	**Telephone**	**Date (dd/mmm/yyyy)**

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

G. Patient'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.

Name	Signature	Date (dd/mmm/yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.