WSCC Workers' Safety & Compensation Commission | ᐃᖅᑲᓇᐃᔨᖅᑎᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪ ᓇᓪᓕᐅᒃᑯᒫᓂᒃ ᖃᐅᔨᓴᖅᑏᑦ

Psychiatric/ Psychological Initial Report

Complete this form and return it, with your invoice, to the address on the reverse.

Worker Information

Last Name	First Name	
Mailing Address (include postal code)	Claim Number	Telephone (include area code)
Employer	Worker's Occupation	
Date of Injury MM | DD | YY	Date of Birth MM | DD | YY	Gender ☐ M ☐ F

Psychologist Information

Name of Psychologist, Registration, and Licence Number (please print)	
Telephone (include area code)	Address (include postal code)
Date of Service MM | DD | YY	

Subjective

Presenting Problem

Relevant History (make note of prior or current non-incident related problems that may affect recovery).

Worker's Last Name	First Name	Claim Number

Clinical Formulation and/or Diagnosis (if Worker only meets partial diagnostic criteria, indicate [sub-clinical]).

Primary Treatment Goals

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Treatment Plan (indicate anticipated number of sessions and session frequency).

Are there Psychological Barriers to a return to work? ☐ Yes ☐ No *(If yes, please explain.)*

Objective

Test Results (name of test, evidence of validity of results, summary interpretations).

Is worker fit to return to work with no restrictions? ☐ Yes ☐ No

I hereby certify the above is a correct statement of services personally rendered by myself.

Psychologist's Signature ______________________________ Date ____________________

The WSCC may use this information for the administration of legislation under our authority, including the *Workers' Compensation Acts,* the *Safety Acts,* and/or the *Mine Health and Safety Acts*, and their associated *Regulations*, and to contact you in relation to the requirements under the relevant legislation.

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or
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