Saskatchewan Workers' Compensation Board

Health Care Services
200 - 1881 Scarth Street
Regina, SK S4P 4L1
Online: www.wcbsask.com/care-providers

Tel: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll-free fax: 1.888.844.7773

PSYP

Psychology - Progress/Discharge Report

Psychologist name: _____ **WCB claim number:** _____

Degree: _____ **SCP:** _____ **Date of injury:** _____

Clinic number: _____ **Provincial Health number:** _____

Tel: _____ **Fax:** _____ **Date of birth:** _____ **Tel:** _____

Date of initial session: _____ **Employer name:** _____

Clinic name, address and postal code:

Injured worker's name, address and postal code:

- *Use DSM-V for any diagnostic information, with the exception of GAF (global assessment of functioning) from DSM-IV-TR.*
- *This form is expected to contain answers to questions and concise statements that clearly address the issues.*
- *If treatment is occurring in a secondary or tertiary treatment centre, it is to be integrated and sent within the treatment centre.*

This is a

☐ Progress report ☐ Discharge report

Choose one, either by checking the appropriate line or delete the one that does not apply.

Date of report: _____

Date of discharge: _____
Include if this is a discharge report, otherwise delete this line.

Date of initial session: _____

DSM-V diagnoses treated: _____

GAF-current (global assessment of functioning) (DSM-IV): _____

List any updated clinical information, different than last progress report:

Supporting the injured worker to stay at work or return is the primary goal of mental health treatment. Please identify return to work (RTW) factors and restrictions: *Be specific, using the WCB List of Restrictions information sheet as a guide. Always avoid stating specific work locations and work positions because these are the employer responsibilities, e.g., it is acceptable to say "the injured worker needs to avoid …..", but not "the injured worker should work in <name of job position or location>".*

Claim number: _____

Is the treatment plan following the mental health assessment (MHA) recommendations:

☐ Yes ☐ No

If no, has WCB Health Care Services been contacted to alert and explain change in treatment plan or RTW schedule?

☐ Yes ☐ No

If no, please explain:

(Psychologist must contact if not within a secondary or tertiary treatment centre. Within treatment centre, team shall contact Health Care Services Manager, leave message at 306.787.7760)

WORK AND FUNCTIONAL INFORMATION

This section is completed by the psychologist, or if in a treatment centre, jointly with the clinic therapist

Name of employer or business: _____
(omit if a treatment centre report)

Employer contact name for RTW: _____
(omit if a treatment centre report)

Employer tel: _____
(omit if a TX centre report)

Employer fax: _____
(omit if a treatment centre report)

Is the injured worker functional at home and daily tasks?

☐ Yes ☐ No

What specific goals were set for function at home and daily tasks for this reporting period?

Did the injured worker meet each goal? *(be specific re goals met and not met)*

Describe any functional limitations at home: *include management of activities of daily life (ADL) and non-work activities such as shopping, child care and leisure activities.*

What activities of daily living is the injured worker involved in? *(comment on childcare, personal care, shopping, leisure activities, volunteer work, home business, etc.)*

Is the injured worker participating in a physical exercise program? *(applies only to injured workers in tertiary treatment centres)*

☐ Yes ☐ No

If yes, specify the schedule:

Has the injured worker missed any scheduled psychology appointments?

☐ Yes ☐ No

Number missed to date: _____

Has the injured worker missed any scheduled exercise appointments?

☐ Yes ☐ No

Number missed to date: _____

If yes, specify reason: *e.g. 3/slept in*

Is the injured worker at work?

☐ Yes ☐ No

If yes, are these

☐ Regular duties ☐ Accommodated duties

List schedule and restrictions if any:

Are the RTW recommendations from the MHA being followed?

☐ Yes ☐ No

Details: *Include: if recommendations are not being followed, why?*

If no, has WCB Health Care Services been alerted to allow for resource review?

☐ Yes ☐ No

If no, why not?

If not at work, is the injured worker ready for RTW performing full duties?

☐ Yes ☐ No

If not at work, is the injured worker ready for accommodated work?

☐ Yes ☐ No

If ready for only accommodated work, list psychological restrictions and limitations: *Be specific, using the WCB List of Restrictions information sheet as a guide. Always avoid stating specific work locations and work positions because these are the employer responsibilities, e.g., it is acceptable to say "the injured worker needs to avoid …..", but not "the injured worker should work in <name of job position or location>".*

If not at work, have you *(or treatment centre personnel)* contacted the employer regarding RTW plans?

☐ Yes ☐ No

If no, why not? *It is a general expectation that the employer be contacted for discussion of return to work. Such discussions should concern current restrictions and details of employer offers of any alternate duties which accommodate the restrictions.*

Details of the RTW discussion with the employer: *Include projected timeline and any details of progression known.*

Are workplace visits (live exposure) required?

☐ Yes ☐ No

Details: *Include timeline, what the injured worker requires exposure to, schedule, outcome of discussion of live exposure with employer as known. If the decision is pending about live exposure, state what is required to determine the need.*

Claim number: _____

Have you discussed RTW planning and time frames with the injured worker?

☐ Yes ☐ No

Is the plan accepted:

By injured worker? ☐ Yes ☐ No

By employer? ☐ Yes ☐ No

Details:

Focus of treatment:

Are there any external, non-claim issues that may delay recovery?

☐ Yes ☐ No

Details:

Are there any additional risk factors for recovery?

☐ Yes ☐ No

List other issues of clinical relevance not part of claim:

Psychologist's signature: _____ **Date:** _____

Treatment centre therapist's signature: _____ **Date:** _____
(Omit if not in a treatment centre)