WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

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Visit our website: wcb.ns.ca

Psychology Assessment Form: REPORT

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Claim Number:

Worker's Last Name	Worker's First Name	Init.
Date of Injury (MM/DD/YYYY)		

D. Clinical Information

1. Worker's description of injury, including history of events/exposures if relevant:

2. Current symptoms:

Please provide brief summary of standardized inventories used (e.g. BAI, PCL-5):

3. DSM Diagnosis:

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4. Approximate period/date of onset for psychological symptoms described above:

5. Are you aware of any pre-existing psychological conditions, or other relevant/contributing factors?

If so, describe briefly (e.g., date of onset, previous treatment, treatment provider). Was this issue/condition resolved?

6. Behavioural observations during assessment:

7. Impairments in day-to-day function: comment on social, family and other:

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E. Psychological Treatment Plan

☐ No psychological treatment required (please proceed to Section E) **OR**

***In all cases, a Progress Form is required at the end of every 4th session or 4th week, whichever comes first.**

8. Treatment goals:

9. Treatment interventions:

What evidence-based treatments will be used to meet each of the treatment goals outlined above?

Treatment Frequency:

☐ Weekly
☐ Monthly
☐ Other

10. In your opinion, is the worker at imminent risk of harm to himself / herself or others?

If so, please explain including level of risk, and provide plan.

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F. Occupational Function information

Functional Abilities:

Based on the worker's current job duties, please describe the tasks the worker is able to perform:

Based on the worker's current job duties, please describe the tasks the worker is unable to perform:

Employment status at time of initial psychological assessment: ☐ Full Time **OR** ☐ Part Time

☐ Not Working Comments:

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For workers who are not back at work in some capacity: Using the scale below, please provide an overall estimate of the worker's readiness to work **from a mental health perspective (not physical)**.

In general, how ready is this worker to be back at work?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not Ready — Very Ready

Identify the factors / barriers impacting return to work (e.g. Harassment, lack of accomodation, etc.):

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For workers who are working in some capacity: Using the scale below, please provide an overall estimate of the likelihood the worker will be able to stay at work, **from a mental health perspective (not physical)**.

In general, how likely is this worker able to stay at work?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not likely — Very likely

Comment on factors impacting the worker's ability to stay at work:
What additional supports (e.g. occupational therapist, medication) would assist the worker to stay at work:

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Any other relevant comments:

Psychologist Signature	Date
Health Professional's Name (PLEASE PRINT IN BLOCK LETTERS)	
Name of Clinic	

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