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

5668 South Street
PO Box 1150
Halifax, NS B3J 2Y2

Phone: 902.491.8324
Fax: 902.491.8001
Toll free: 1.877.211.9267

Visit our website: wcb.ns.ca

Psychology Progress Form: INVOICE

Claim Number:

PRINT | RESET | SAVE

Invoice Date (MM/DD/YYYY):

Invoice Number:

- **Form must be submitted within 14 calendar days of the last visit.**
- **No other invoice submission is necessary.**

A. Worker Information

Last Name	First Name	Init.
Address (no. street, unit)		
City/Town	Prov.	Postal code
Date of Birth (MM/DD/YYYY)	Telephone No.	☐ Worker did not return/self-discharged
Employer Name		Telephone No.

B. Health Professional Information

☐ Psychologist ☐ Clinical Counsellor ☐ Social Worker

Practioner's Name	Facility Name

Date of Service/Treatment (MM/DD/YYYY)	Treatment type	Amount Billed
	HST	
	TOTAL	

C. Payee

Make payment payable to:		
Name of Clinician		
Facility Name	Company	
Care of		
Address (no. street, unit)		
City/Town	Prov.	Postal Code
Telephone No.	Fax No.	

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Date of Injury (MM/DD/YYYY)		

D. Treatment Progress and Response

1. Has the DSM diagnosis remained the same?

If **no**, please include change in DSM diagnosis update:

2. Treatment goals previously identified:

3. Evidence based treatment interventions/approaches provided to date:

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4. Response to treatment:

☐ No improvement ☐ Minimal Improvement ☐ Moderate Improvement ☐ Significant Improvement ☐ Fully resolved

If not responding, why? Are you considering other treatment modalities?

5. Functional status for day-to-day activities (social, other):

(If more space is needed, continue on next page)

17/AUGUST/2020

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Question 5 – response continuation:

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E. Psychology Treatment Plan

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

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

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:

Expected Duration:

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Current Employment status: ☐ Full Time **OR** ☐ Part Time
☐ Not Working Comments:

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 any additional barriers impacting return to work, not previously reported:

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Claim Number:

Worker's Last Name	Worker's First Name	Init.

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 any additional factors impacting the worker's ability to stay at work, not previously reported:
What additional supports (e.g. occupational therapist, medication) would assist the worker to stay at work:

Health Professional Signature	Date (MM/DD/YYYY)
Health Professional's Name (PLEASE PRINT IN BLOCK LETTERS)	
Name of Clinic	

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