

This form is for out-of-province providers to complete. Please fax or mail the completed form to us using the information on the form.

Claim Number:

PRINT	RESET	SAVE
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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				
Practitioner'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.		

Claim Number:

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

Claim Number:

Question 5 – response continuation:

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Worker's Last Name

Worker's First Name

Init.

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:

Claim Number:

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

Claim Number:

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