Workers' Compensation Board
Alberta

P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: (780) 427-5863
1-800-661-1993

C-851
PSYCHOLOGY SERVICES
Initial Report

Please print clearly or type.

WCB Claim Number	Personal Health Number	Date of Accident *(yyyy/mm/dd)*

Worker's Surname	First Name	Initial	Date of Birth *(yyyy/mm/dd)*

Address Street	City/Town	Province	Postal Code	Telephone Number ( )

Referral Source Name	Referral Source Contact Telephone Number ( )

Provider Name	Provider Contact Telephone Number	Provider File Number

Date Seen *(yyyy/mm/dd)*

1. Reason for referral:

2. Presenting problems (vocational and rehabilitation barriers):

3. Relevant personal history and background information:

4. Clinical impression:

5. Treatment goals (behaviorally stated & timeframes):

a)

b)

c)

6. Treatment plan:

a)

b)

c)

7. Factors affecting treatment/prognosis:

If you have any questions regarding the information or would like to discuss, please contact the undersigned.

Therapist's name _____ Contact telephone number _____ Date *(yyyy/mm/dd)* _____

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.