Workers' Compensation Board
Alberta

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

C-853
PSYCHOLOGY SERVICES
Final 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(s) Seen *(yyyy/mm/dd)*		Number of Sessions to Date

1. Reason for referral:

2. Summary of therapy in this period:

3. Current status re: presenting problems (vocational and rehabilitation barriers):

4. Treatment goals and time frames (from previous progress report):

5. Current status re: above treatment goals (met/partially met/not met):

a)

b)

c)

6. Additional comments (e.g., new concerns & issues):

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.