Psychology Online Reporting User Guide

Workers' Compensation Board – Alberta

wcb Workers' Compensation Board – Alberta

This page is included so the cover will have a blank flip-side
when printing double-sided. It can be deleted if saving as a PDF.

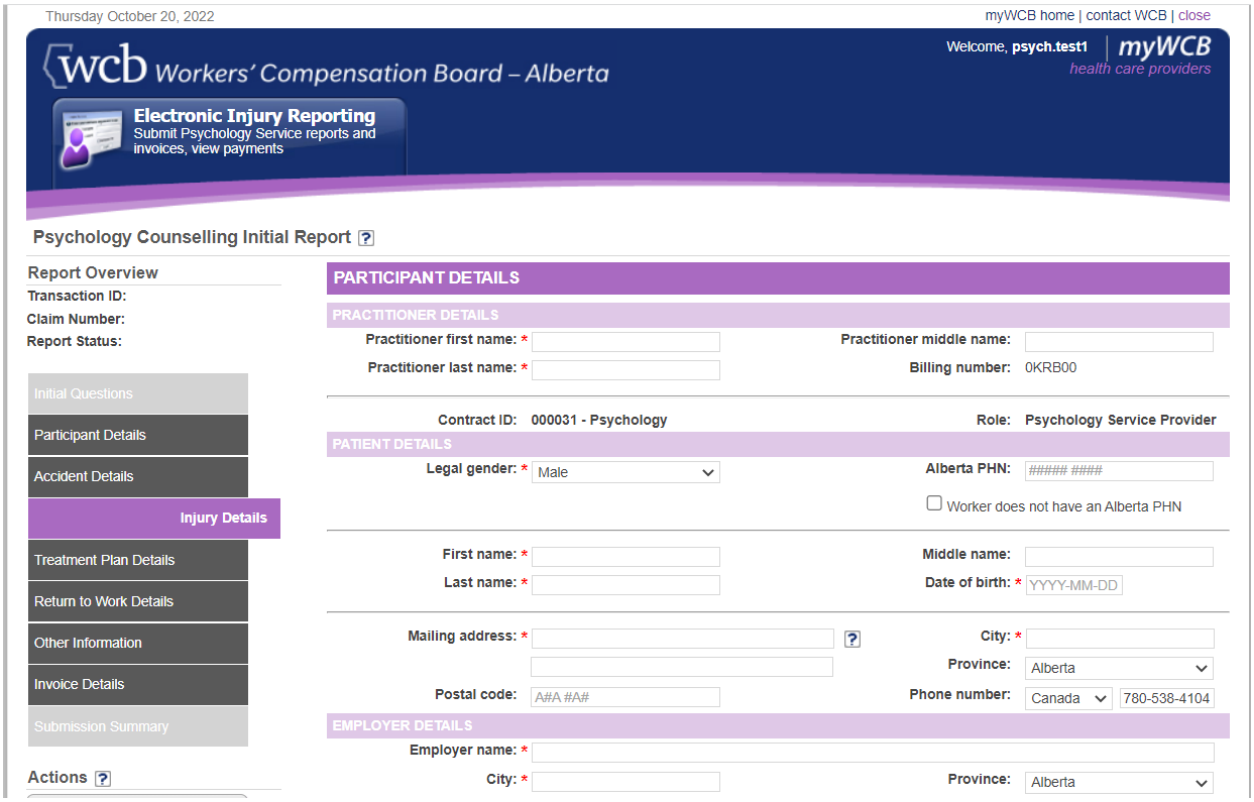
Table of Contents

Electronic Injury Reporting – Psych Counselling Initial, Progress, Discharge and Extension Reports – C851, C852, C852D, C852E

All Mandatory Fields are denoted by (*)

This Electronic Injury Reporting System is enabled with a show/hide function. Depending on how you answer some questions, additional fields may be available or unavailable for completion.

For example, if it is indicated that a worker has missed time from work additional information regarding the time loss is required and therefore additional fields will be visible for completion. If information is entered and the initial answer is later changed to indicate the worker did not miss time from work the additional fields will no longer be visible, and any information previously entered in them will not be saved.



Participant details

This section may be pre-populated if there is a claim number or previous report, and will display the billing number, practitioner information, the worker's Alberta PHN, name, date of birth, address and employer name.

Selecting the *View/Modify* button will open the detailed view and allow the user to make changes.

If there are any errors in the participant details section when the report is saved or submitted, the detailed view will automatically open and prompt the user to make the required changes.

Practitioner details

- The following fields identify the practitioner who rendered treatment and may be pre-populated from previous reports or require the user to enter the information:
    - Practitioner first name *,
    - Practitioner middle name, and
    - Practitioner last name*.
- The *Contract ID*, *Role* and *Billing Number* will be pre-populated and cannot be changed.

Worker details

Legal gender *

- This field may be pre-populated from previous reports.
- If not pre-populated, indicate the gender of the worker by selecting *Female, Male or* X.

Alberta Personal Health Number (PHN) *

- Enter an Alberta PHN (the following formats are accepted ##### ####, #########, #####-####).
- If the worker does not have an Alberta PHN select the check box that states *Worker does not have an Alberta PHN*. This will clear the Alberta PHN check box field.

First and last name *

- The worker's name must be a legal name and should correspond with the name associated with the PHN if provided.
- The worker's middle name should be included if provided as this will help identify the worker (this field may not be available if the worker's name was pre-populated).

Date of birth *

- Enter the worker's date of birth (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).
- A warning will occur when there is less than 12 years between the date of birth and the current date.

Mailing address *

- The worker's current street address including the unit number if applicable (e.g., # 802 11520 – 89 Avenue).
- Note, the worker's mailing address may be different from the worker's physical address.
- WCB will use the mailing address to correspond with the worker.
- Two address lines are provided, however, only line one is required.

Note: If the mailing address does not match Canada Post standards, you will receive a warning. Please select the suggested address, when available, or the address you entered. Click on *Edit* to enter a different address.

City *

- Enter the city or town where the worker resides. Abbreviations will not be accepted.

Province

- The system defaults to Alberta, alternate provinces and states can be selected from the drop-down list.
- The drop-down list has a *please choose* option for addresses from another country.

Postal Code

- Enter a valid postal code for the worker's address, (enter the postal code as L#L#L# for addresses in Canada).
- If a U.S. state is selected in the province field, enter the zip code (enter as ##### or ######-####).

Phone Number

- The country field is pre-populated with Canada. A different country can be selected from the drop-down box.
- If a country code other than Canada or the U.S. is selected the country code may populate automatically.
- Enter the worker's phone number.
- If entering a Canadian or U.S. phone number, enter the area code and a seven digit phone number (enter the phone number as ###-###-####, ########## or (###) ###-####).
- If entering a phone number for a different country the field will allow up to 24 characters including the country code.

Employer Details

Employer name *

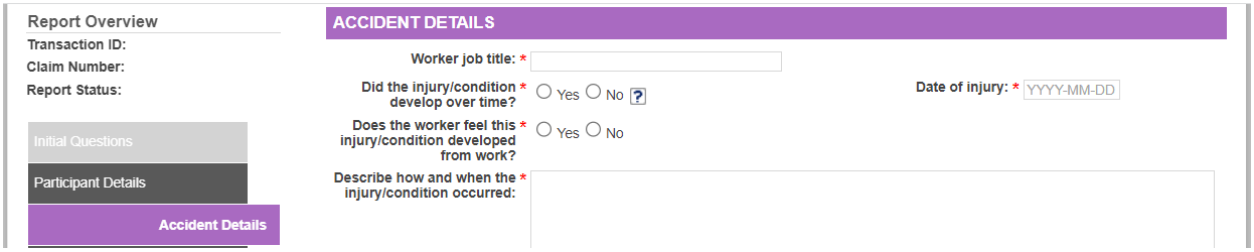
- Enter the name of the worker's employer at the time of the accident/injury.

City *

- Enter the city or town where the employer is located. Abbreviations will not be accepted.

Province

- The system defaults to Alberta, alternate provinces and states can be selected from the drop-down list.
- The drop-down list has a *please choose* option for addresses from other countries.



Accident

Worker job title *

- This field may pre-populate information based on previous reporting or if a previous worker and claim match is detected.
- If the field is blank, enter the position or job title held by the worker at the time of accident/injury.

Did the injury/condition develop over time? *

- Indicate whether the injury occurred over a period of time or from a specific incident and/or distinct event.
- If the injury occurred over a period of time, select *Yes.*
- If the injury was from a distinct incident, or a specific event or accident select *No.*

Date of injury *

- Provide the specific date the accident occurred.
- If the injury/condition developed over time, use the date that the worker first sought psychological treatment (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).
- The date of injury must be on or before the current date and the difference between the date of injury and date of birth must be greater than 12 years otherwise a warning generate.

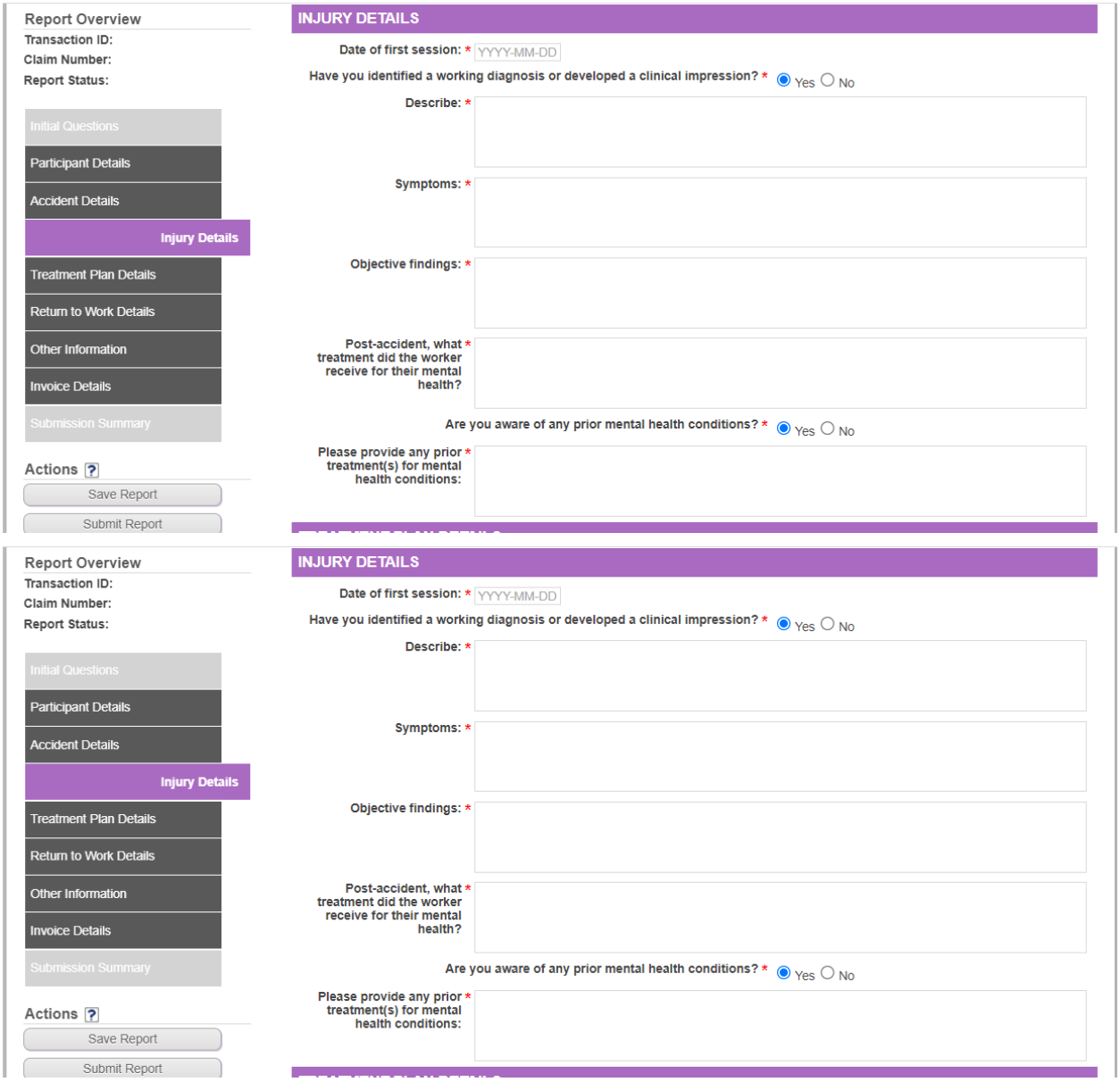
Does the worker feel this injury/condition developed from work? *

- Provide a description of the job duties, demands or other jobs factors the worker believes increased or caused the symptoms.

Describe how and when the injury/condition occurred *

- Provide a description of the circumstances around the incident and how the incident occurred.

If the injury or condition developed over time, provide a description of the job duties and physical demands that increased or caused the symptoms.



Report Overview
Transaction ID:
Claim Number:
Report Status:
Initial Questions
Participant Details
Accident Details
Injury Details
Treatment Plan Details
Return to Work Details
Other Information
Invoice Details
Submission Summary
Actions
Save Report
Submit Report
INJURY DETAILS
Date of first session: * YYYY-MM-DD
Have you identified a working diagnosis or developed a clinical impression? * Yes No
Describe: *
Symptoms: *
Objective findings: *
Post-accident, what treatment did the worker receive for their mental health? *
Are you aware of any prior mental health conditions? * Yes No
Please provide any prior treatment(s) for mental health conditions: *

Injury

Date of first session *

- Enter the date of first session (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).
- The date of session must be:
  - prior to or equal to the current date,
  - prior to or equal to the report completion date,
  - after or equal to the date of injury, and

- the difference between the date of assessment and date of birth must be greater than or equal to 12 years otherwise a warning message will be generated.

Have you identified a working diagnosis or developed a clinical impression? *

- Select *Yes* or *No* based on if you have identified a working diagnosis or developed a clinical impression.

Describe *

- Please provide a working diagnosis or clinical impression based on a DSM-5 TR.

Symptoms *

- Enter the symptoms that the worker exhibits.
- Include how the worker describes the symptoms (e.g., number of hours slept, reported mood, thought process, etc.).

Objective findings *

- Describe nature of symptoms and include things like hygiene, activities of daily living, ability to engage in functional domains, affect, etc.

Post-accident, what treatment did the worker receive for their mental health? *

- Please provide information found in the medical package and/or provided by the worker. Examples: GP, family/peer support, EAP, counselling, etc.

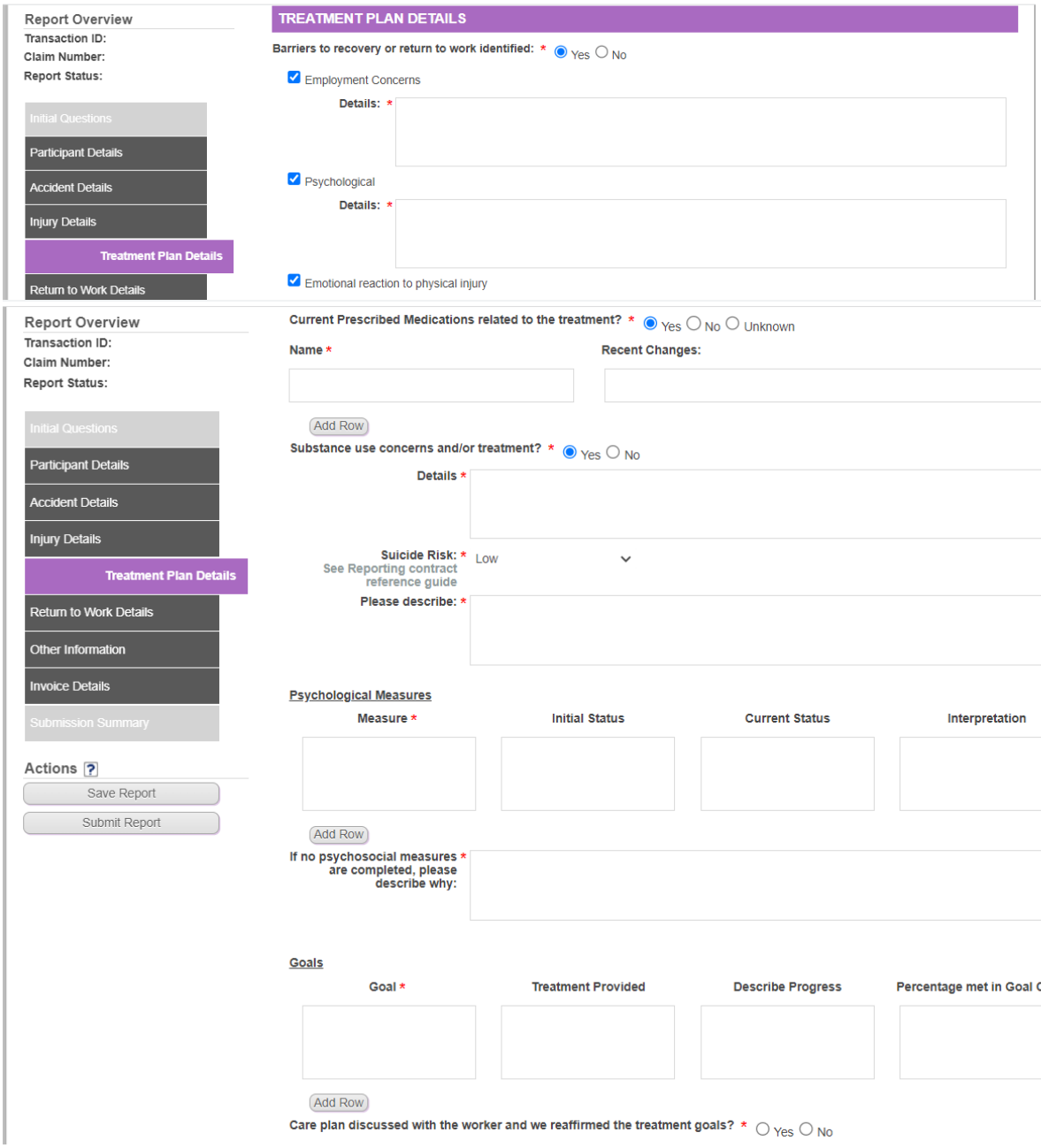
Are you aware of any prior mental health conditions? *

- Select *Yes* if information found in medical package and/or reported by worker.
- Select *No* if there is no evidence of a prior mental health condition found in the medical package and/or reported by the worker.

Please provide any prior treatment(s) for mental health conditions *

- If applicable, please provide a history of past treatments for mental health condition(s).

Treatment Plan C851/852



Barriers to recovery or return to work identified? *

- Select *Yes* of *No* to identify if there are barriers to the worker's recovery or return to work.

Employment concerns

- Select if barriers are related to the workplace.

Details *

- Provide details on barriers related to the compensable injury (e.g., Not job attached, lack of appropriate modified work etc.) **or** non-compensable (dislikes job, toxic work environment (feeling unsupported, burnout), interpersonal issues with management, denied vacation requests, etc.)

Psychological

- Select if barriers are psychological in nature.

Details *

- Please provide details on barriers related to psychological condition (e.g., anxiety, avoidance, lack of sleep, etc.).

Emotional reaction to physical injury

- Select if primary nature of injury is physical and injury is a barrier.

Details *

- Please provide details on barriers related to physical injury (e.g., pain focused).

Other (i.e., non-compensable conditions)

- Select if barriers are not related to any of the above categories.

Details *

- Please provide more information about the recovery or return to work barriers not listed in other categories.

Anticipated treatment

Select one of the following anticipated treatment options from the drop-down:

- Short term supportive counselling: If the presenting problem is estimated to be resolved in less than five sessions.
- Treatment for a psychological condition: If the presenting psychological condition is estimated to be resolved in more than five sessions of treatment.
- Counselling for family member of deceased worker: If the worker is deceased and treatment is for the worker's family member.
- Joint family counselling: If family and/or couple counselling is required to remove barrier to return to work.
- No further psychological services are required: If you are not recommending any further counselling sessions.

Treatment plan *

- Describe the proposed treatment and encouraged activities including work, daily living routine and therapy homework. Describe the outcome/goal of the treatment in relation to return to work.

- Please advise if treatment is being completed in person, virtually or a blend of both.

Any comments on worker's presentation, function and/or affect that you believe may interfere with return to work or normal social functioning? *

- If outside normal limits, describe any issues with attendance, behaviors, comprehension, emotional response, speech quality, judgment or mood. If within normal limits, please enter no concerns with presentation".

WCB Services for consideration

- Select from options only if applicable.

Case conference with claim owner

- Select if you would like to be contacted by the WCB claim owner.

Details

- For example, provide a brief description of what you would like to discuss with the claim owner (e.g., modified work).

Case conference with WCB psychology consultant

- Select if you would like to be contacted by a WCB psychology consultant.

Details

- For example, a brief description of what you would like to discuss with the psychological consultant (e.g., help with goal percentage).

Interdisciplinary treatment services

- Select if the worker's issues are complex and require the support of a multidisciplinary team. If selected, counselling services would continue in a Return-to-Work program (e.g., Complex Pain program or Traumatic Psychological Injury (TPI) program).

Details

- Provide rationale to support a multidisciplinary program.

Further assessment

- Select if you would like the claim owner to consider a more comprehensive assessment.

Details

- Describe the purpose of the proposed assessment: to help confirm diagnosis, temporary and/or permanent restrictions, return to work and/or further treatment recommendations.

Other counselling support for non-work injury related stressors/concerns

- Select if you have identified a need for a non-work-related counselling.

Details

- Specify what kind of treatment should be considered for client (e.g., grief counselling, life stressors management, etc.)

Occupational therapy

- Select if you want the claim owner to consider concurrent treatment with an occupational therapist (e.g., exposure treatment).

Details

- Please provide rationale for considering the involvement of an occupational therapist to support the care plan.

Details

- Please provide rationale for considering the involvement of an occupational therapist to support the care plan.

Family counselling

- Select if you would like the claim owner to consider counselling for worker's immediate family members.

Details

- Provide brief explanation of services to be considered.

Current prescribed medication related to treatment? *

- Indicate if the worker is using prescribed medication related to treatment by selecting *Yes, No* or *Unknown*.

Name *

- Name and/or DIN of prescribed medication(s).

Recent changes

- Identify any changes in dosage (e.g., from 5 mg to 10 mg).

Add Row

- If more than one medication, please add a row and follow steps above to enter information.

Substance use concerns and/or treatment? *

- Indicate if there are any substance use concerns and/or treatment by selecting *Yes* or *No*.

Details

- Please describe previous and/or current substance abuse use, current symptoms and treatment to date.

Suicide risk *

☐ No risk	☐ Low	☐ Medium	☐ High
	• No plan • No intent • No time frame • Multiple protective factors (e.g., family, friends, faith)	• Some plan • No immediate intent • Vague or distant time frame • Some protective factors (e.g., family, friends, faith)	• Active plan • Expressed intent • Access to means (e.g., pills, gun, rope, vehicle) • Imminent time frame • Minimal or limited protective factors

Please describe *

- Identify the unique risk and protective factors. Individuals may have different responses to the same stressor or protective factor. Identification may help with future care planning. Please outline any risk factors and protective factors.
- If required, please outline a risk management plan. If a worker has suicidal or homicidal ideation, has a plan, and you believe they or others are at immediate risk, please follow your office emergency procedures, which may include calling 911 or mobile crisis. Please call and inform WCB once the emergency has been stabilized.

Psychometric table

Measure *

- Please provide at least one psychological measure (e.g., BDI, BAI, HADS, PDI).

Initial status

- Document the psychometric tool baseline.

Current status

- Document the psychometric tool current status.

Interpretation

- Please provide interpretation of the updated psychometric measures for example GAD 7, initial 14 (moderate), current 16 (moderate), interpretation - anxiety score increased slightly.

Add row

- If more than one psychometric measure used, please add a row and follow steps above.

If no psychosocial measures are completed, please describe why *

- If you did not complete any psychosocial measures, please provide rationale.

Goals table

Goal *

- Goals that will be worked on during treatment (e.g., return to work, reduce anxiety symptoms).

Treatment provided

- Please provide treatment method and modality (CBT, supportive counselling and return to work planning).

Describe progress

- Indicate stage of progress reached during the reporting period based on your clinical opinion, observations and objective measures.

Percentage met in goal overall

- Include a best estimate of how much of the goal has been met as a percentage. For clinical support for how to determine the percentage, contact the WCB- psychology consultants.

Add row

- If more than one goal, please add a row and repeat steps above.

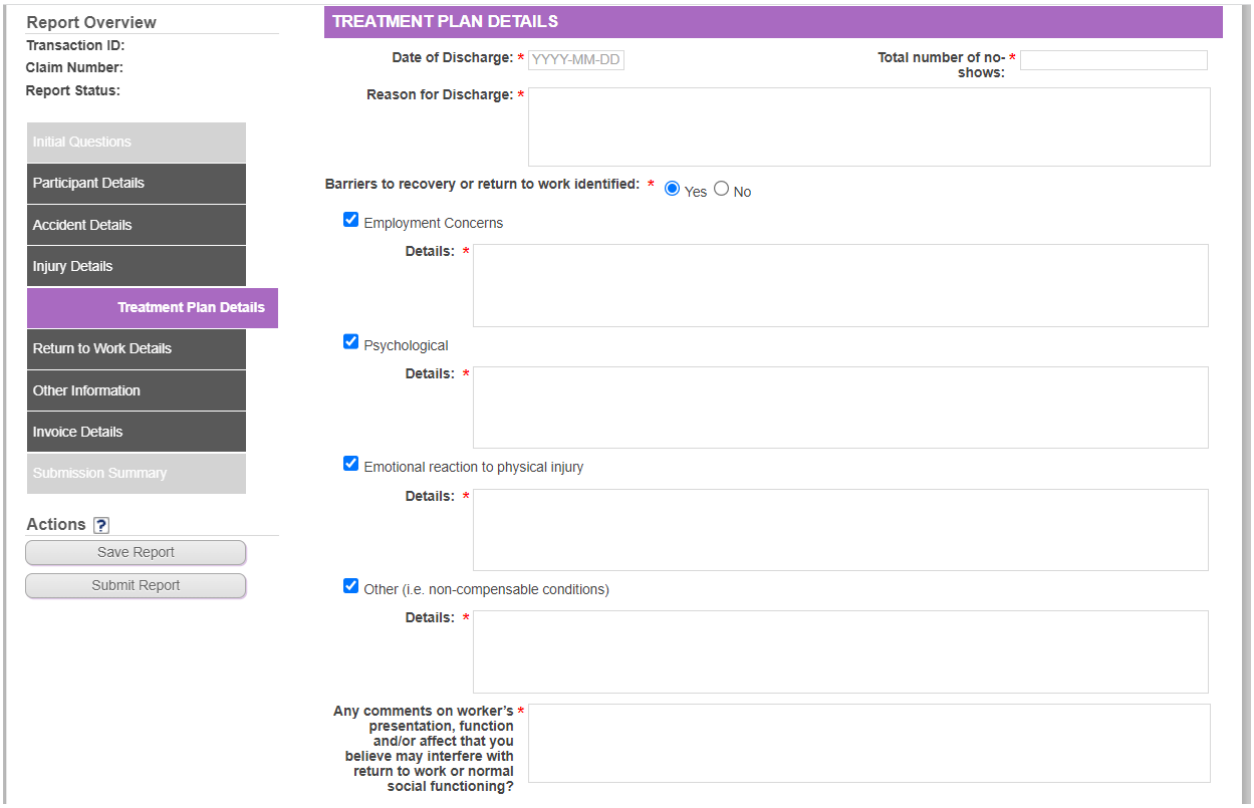
Remove

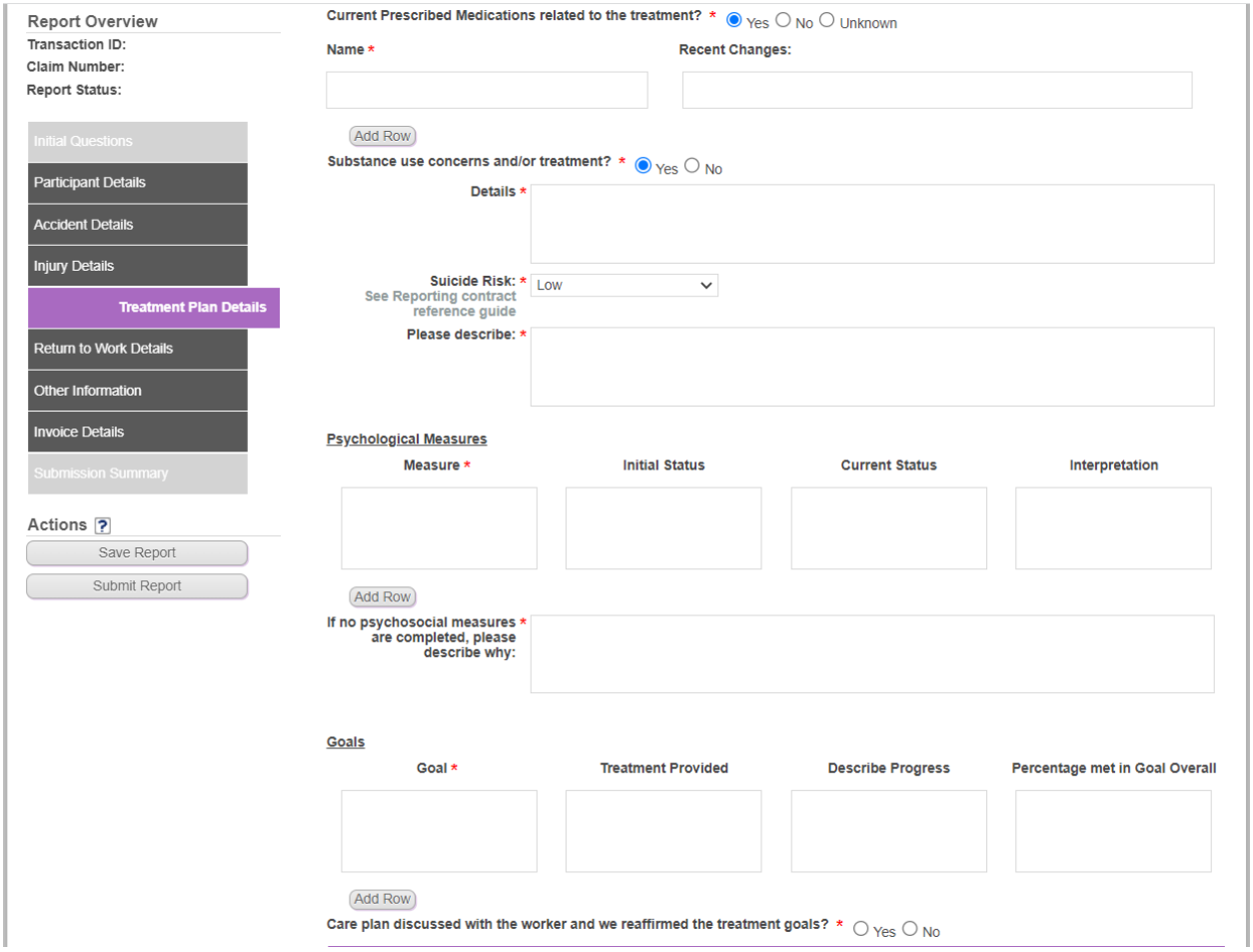
- If the goal was added in error, use this button to remove it from the report.

Care plan discussed with the worker and reaffirmed treatment goals? *

- Indicate if the care plan was discussed with the worker and the treatment goals were reaffirmed by selecting *Yes* or *No*.
- Please describe how you plan to taper counselling support as progress is made.

Treatment Plan C852D





Date of discharge *

- Enter the date of discharge (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).
- The date of session must be:
  - prior to or equal to the current date,
  - prior to or equal to the report completion date, or
  - after or equal to the date of injury.

Total number of no-shows *

- Number of scheduled sessions worker did not attend.

Reason for discharge *

- Outline reason for discharge (e.g., return to full duties, no participation).

Barriers to recovery or return to work identified? *

- Select *Yes* or *No* based on barriers to the worker's recovery or return to work.

Employment concerns

- Select if barriers are related to the workplace.

Details *

- Provide details on barriers related to the compensable injury (e.g., not job attached, lack of appropriate modified work, etc.) or non-compensable (dislikes job, toxic work environment, feeling unsupported, burnout, interpersonal issues with management, denied vacation requests, etc.).

Psychological

- Select if barriers are psychological in nature.

Details *

- Please provide details barriers related to psychological condition (e.g., anxiety, avoidance, lack of sleep, etc.).

Emotional reaction to physical injury

- Select if primary nature of injury is physical and injury is barrier.

Details *

- Please provide details on barriers related to physical injury (e.g., pain focused).

Emotional reaction to physical injury

- Select if primary nature of injury is physical and injury is barrier.

Details *

- Please provide details on barriers related to physical injury (e.g., pain focused).

Other (e.g., non-compensable conditions)

- Select if barriers are not related to any of the above categories.

Details *

- Please provide more information about the recovery or return to work barriers which are not listed in other categories.

Any comments on worker's presentation, function and/or affect that you believe may interfere with return to work or normal social functioning? *

If outside normal limits, describe any issues with attendance, behaviors, comprehension, emotional response, speech quality, judgment, or mood. If within normal limits, please enter, "no concerns with presentation".

WCB services for consideration

- Select from options, only if applicable.

Case conference with claim owner

- Select if you would like to be contacted by the WCB claim owner.

Details

- Provide rationale to support a multidisciplinary program.

Further assessment

- Select if you would like the claim owner to consider a more comprehensive assessment.

Details

- Describe the purpose of the proposed assessment: to help confirm diagnosis, temporary and/or permanent restrictions, return to work and/or further treatment recommendations.

Other counselling support for non-work injury related stressors/concerns

- Select if you have identified a need for a non-work-related counselling.

Details

- Specify what kind of treatment should be considered for client (e.g., grief counselling, life stressors management, etc.).

Occupational therapy

- Select if you want the claim owner to consider concurrent treatment with an occupational therapist (i.e., exposure treatment).

Details

- Please provide rationale for considering the involvement of an occupational therapist to support the care plan.

Family counselling

- Select if you would like the claim owner to consider counselling for worker's immediate family members.

Details

- Provide brief explanation of services to be considered.

Current prescribed medication related to the treatment? *

- Indicate if the worker is currently under prescribed medication related to the treatment by selecting *Yes, No* or *Unknown*.

Name *

- Name and/or Drug Identification Number (DIN) of prescribed medication(s).

Recent changes

- Any changes in dosage (e.g., from 5 mg to 10 mg).

Add Row

- If more than one medication, please add a row and follow steps above to enter information.

Substance use concerns and/or treatment? *

- Indicates if there are any substance use concerns and/or treatment by selecting *Yes* or *No*.

Details

- Please describe previous and/or current substance abuse use, current symptoms and treatment to date.

Suicide risk *

☐ No Risk	☐ Low	☐ Medium	☐ High
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Please describe *

- Identify the unique risk and protective factors, individuals may have different responses to the same stressor or protective factor. Identification may help with future care planning. Please outline any risk factors and protective factors.

- If required, please outline a risk management plan. If a worker has suicidal or homicidal ideation, has a plan, and you believe they or others are at immediate risk, please follow your office emergency procedures, which may include calling 911 or mobile crisis. Please call and inform WCB once the emergency has been stabilized.

Psychometric table

Measure *

- Please provide at least one psychological measure (e.g., BDI, BAI, HADS, PDI).

Initial status

- Document the psychometric tool baseline.

Current status

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Interpretation

- Please provide interpretation of the updated psychometric measures. For example, GAD 7, initial 14 (moderate), current 16 (moderate), interpretation - anxiety score increased slightly.

Add row

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If no psychosocial measures are completed, please describe why *

- If you did not complete any psychosocial measures, please describe your reasoning.

Goals table

Goal *

- Identify goals that will be worked on during treatment (e.g., return to work, reduce anxiety symptoms).

Treatment provided

- Please provide treatment method, modality (CBT, supportive counselling and return to work planning).

Describe progress

- Indicate stage of progress reached during the reporting period based on your clinical opinion, observations and objective measures.

Percentage met in goal overall

- Include a best estimate of how much of the goal has been met, as a percentage. For clinical support for how to determine the percentage, contact the WCB psychology consultants.

Add goal

- If more than one goal provided, please add a row and repeat steps above.

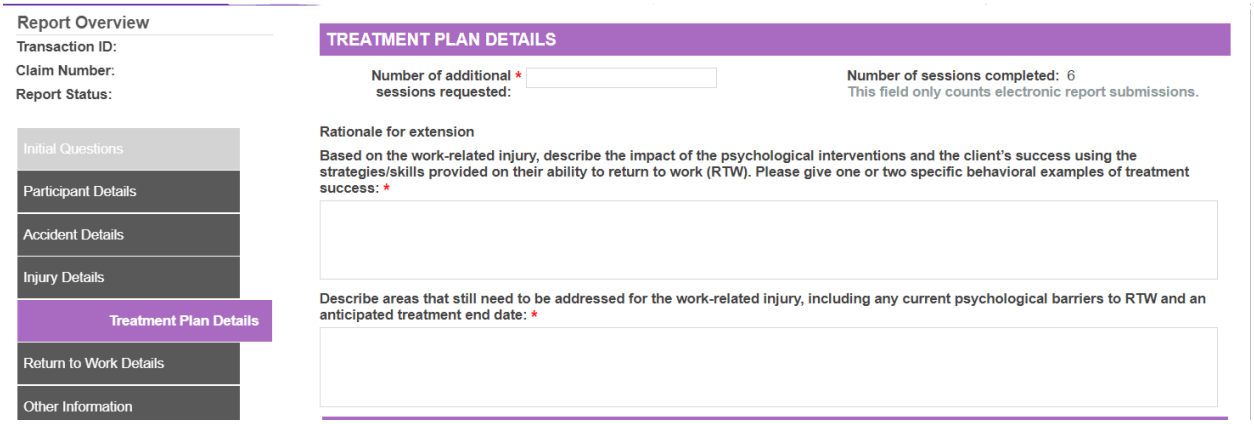
Remove

- If the goal was added in error, use this button to remove from report.

Care plan discussed with the worker and reaffirmed treatment goals? *

- Indicates if the care plan was discussed with the worker and the treatment goals were reaffirmed by selecting *Yes* or *No*.
- Please describe how you plan to taper counselling support as progress made.

Treatment Plan C852E



Number of additional sessions requested

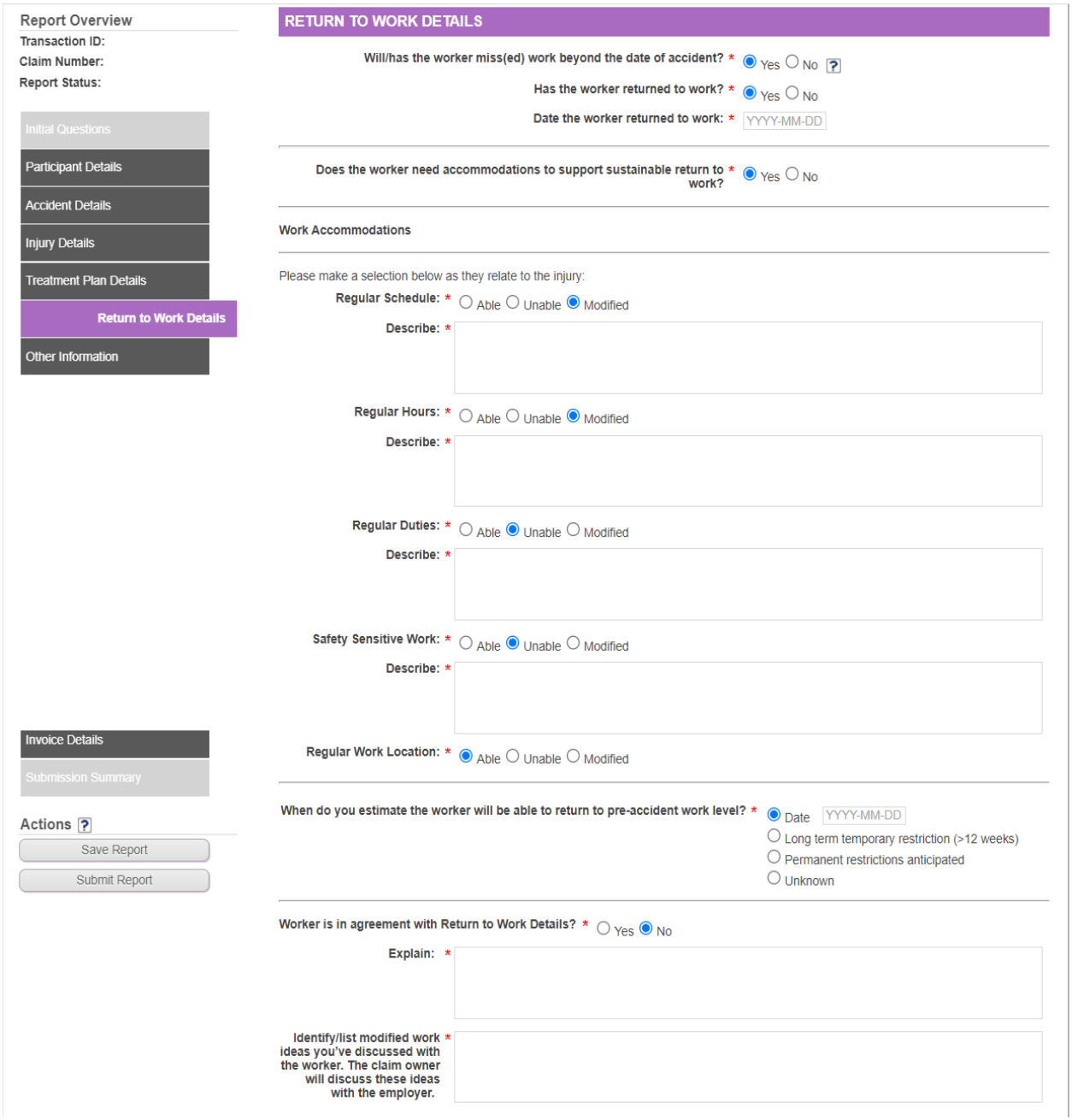
- Please provide the number of future sessions required, not including sessions already approved.

Total number of completed sessions

- Please provide the number of completed sessions.

Rationale for extension

- Please provide the reason for the treatment extension request by answering two mandatory questions.


Report Overview
Transaction ID:
Claim Number:
Report Status:
Initial Questions
Participant Details
Accident Details
Injury Details
Treatment Plan Details
Return to Work Details
Other Information
Invoice Details
Submission Summary
Actions
Save Report
Submit Report
RETURN TO WORK DETAILS
Will/has the worker miss(ed) work beyond the date of accident? * Yes No
Has the worker returned to work? * Yes No
Date the worker returned to work: * YYYY-MM-DD
Does the worker need accommodations to support sustainable return to work? * Yes No
Work Accommodations
Please make a selection below as they relate to the injury:
Regular Schedule: * Able Unable Modified
Describe: *
Regular Hours: * Able Unable Modified
Describe: *
Regular Duties: * Able Unable Modified
Describe: *
Safety Sensitive Work: * Able Unable Modified
Describe: *
Regular Work Location: * Able Unable Modified
When do you estimate the worker will be able to return to pre-accident work level? * Date YYYY-MM-DD
Long term temporary restriction (>12 weeks)
Permanent restrictions anticipated
Unknown
Worker is in agreement with Return to Work Details? * Yes No
Explain: *
Identify/list modified work ideas you've discussed with the worker. The claim owner will discuss these ideas with the employer. *

Return to work

Will/has the worker missed work beyond the date of accident? *

- Answer *no* to this question if:

  - the worker is able to perform regular or modified duties, or
  - the worker is absent from work to attend medical appointments but continues to work except for these appointments.

Answer *yes* if the worker has missed or will miss time beyond the date they were injured at work.

Has the worker returned to work? *

- Select **Yes** or **No**

Date the worker returned to work. *

- Enter the date the worker returned to work after their injury (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).

Does the worker need accommodations to support sustainable return to work? *

- Select *Yes* if a work accommodation will help maintain return to work in any capacity and/or support a return-to-work plan.
- Select *No* if worker will do well completing regular duties and schedule, no accommodations required.

Regular schedule (work accommodations) *

- (pre-accident work schedule, M-F 8 a.m. – 4 p.m.).
- Select *Modified* if a change in work schedule will help worker return to work. Select *Able* if worker is able to work pre-accident schedule. Select *Unable* if worker is unable to work due to psychological injury.

Describe (regular schedule) *

Please provide date of accident schedule and proposed new schedule. If a gradual return to work would work best, please provide detailed plan (e.g., moving from regular schedule M-F 12 hour shifts to M-F 8 hours per **Regular hours (work accommodations)** *

- E.g., 8- or 12-hour shift.
- Select *Modified* if a change in work hours will help worker return to work.
- Select *Able* if worker is able to work pre-accident hours. Select *Unable* if worker is unable to work due to psychological injury.

Describe (regular hours) *

- Please provide date of accident hours and proposed new hours. If a gradual return to work would work best, please provide detailed plan (e.g., regular schedule M-F 8 a.m. - 4 p.m., proposed schedule M-F, 8-12 for two weeks increasing to 8 a.m. -2 p.m. in week three, returning to regular hours 8 a.m. – 4 p.m. in week XX).

Regular duties (work accommodations) *

- Based on job description, physical demands analysis and/or worker's description.
- Select *Modified* if a change in regular work duties will help worker return to work.
- Select *Able* if worker is able to work pre-accident duties. Select Unable if worker is unable to work due to psychological injury.

Describe (regular duties) *

- Please provide date of accident job and proposed new duties. If a gradual return to work would work best, please provide a detailed plan (e.g., administrative assistant, proposed changes in duties - work from home, no contact with public for one month).

Safety sensitive work (work accommodations) *

- Tasks that require complex thought, actions and/or work typically considered hazardous
- Select *Modified* if accommodating for sensitive work duties will help worker return to work.
- Select *Able* if worker is able to perform pre-accident duties and schedule.
- Select *Unable* if worker is unable to work due to psychological injury.

Describe (safety sensitive work) *

- Please provide rationale and time frame expected this will last (e.g., medication doesn't allow cognitive difficulties due to psychological injury - will monitor for a month and update as required).

Regular work location (work accommodations) *

- Indicate *Regular Work Location* (pre-accident work location)
- Select *Modified* if accommodating an alternative workspace will help worker return to work.
- Select *Able* if worker is able to work at pre-accident work location.
- Select *Unable* if worker is unable to work due to psychological injury.

Describe (regular work location) *

- Please provide rationale as to why worker cannot work in their regular workspace. (e.g., work from home due to bullying and harassment at work - monitor for one month and update in next reporting).

When do you estimate the worker will be able to return to pre-accident work level? *

- Enter the date that you expect the worker will be able to return to their regular work with no accommodations required (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).
- If it is estimated the worker will not be able to return to their regular work duties in near future or permanently, select *long term temporary restrictions* or *permanent restrictions anticipated*.
- If uncertain of when worker will be able to return to full duties and hours, and/or if there will be temporary or permanent restriction, choose *unknown*.

Worker is in agreement with return-to-work details? *

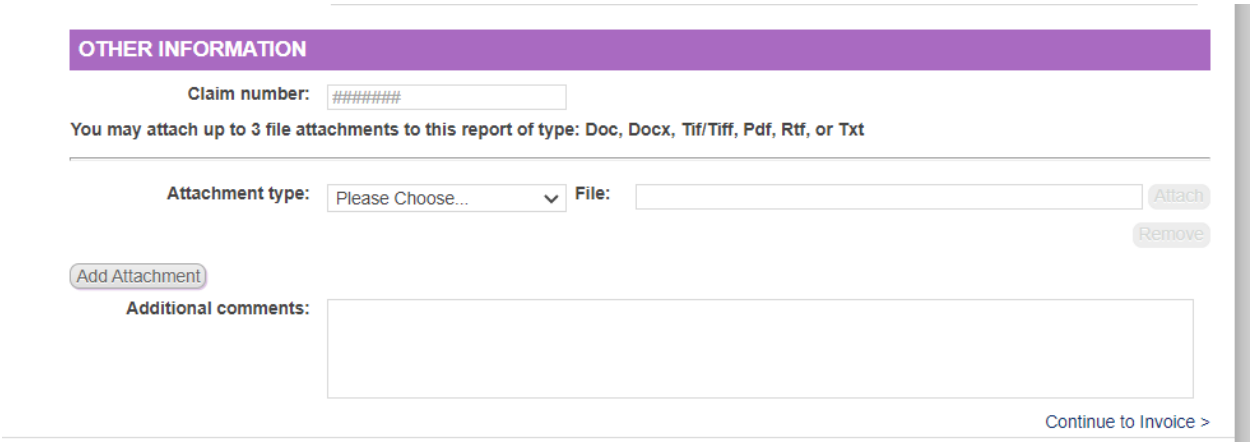
- Indicate if the worker agrees with return-to-work details by selecting Yes or No.

Explain: *

- If *yes* is selected - explain the plan the worker is in agreement with (e.g., gradual return to work plan, week one regular duties, 8 a.m. - 12 p.m. Mon-Fri, week two return to regular duties and hours).
- If *no* is selected - explain what the worker does not agree with, their rationale and your clinical guidance (e.g., worker does not agree that they can work Mon-Fri as they think the anxiety will be overwhelming. You discussed the strategies to use when feeling overwhelmed at work – taking breaks, grounding etc. and reminded worker plan can be adjusted.).

Identify/list modified work ideas you've discussed with the worker. The claim owner will discuss these ideas with the employer.

- Clarify list/ideas for modified work to be discussed with employer to ensure a safe and timely return to work for the worker.



Other Information

This section shows additional questions that are not in any other sections.

Claim number

- This field may be pre-populated based on previous reports.
- If not pre-populated, enter a claim number in for which the form is being submitted.

Note: You may attach up to three file attachments to this report of type: DOC. DOCX, TIFF, PDF, RTF or TXT.

Attachment type

- Select *Additional information* from the drop-down box
- When *Attachment type* is selected, the *File* and *Browse* fields are available.

File

- Provide the address of the attachment file you would like to upload.
- If the attachment type is populated, then the file must also be completed.

Browse

- Click to open a standard browse file dialog box to select a file from your computer.
- If you select a file from the browse button, this will automatically populate the file address field.

Remove

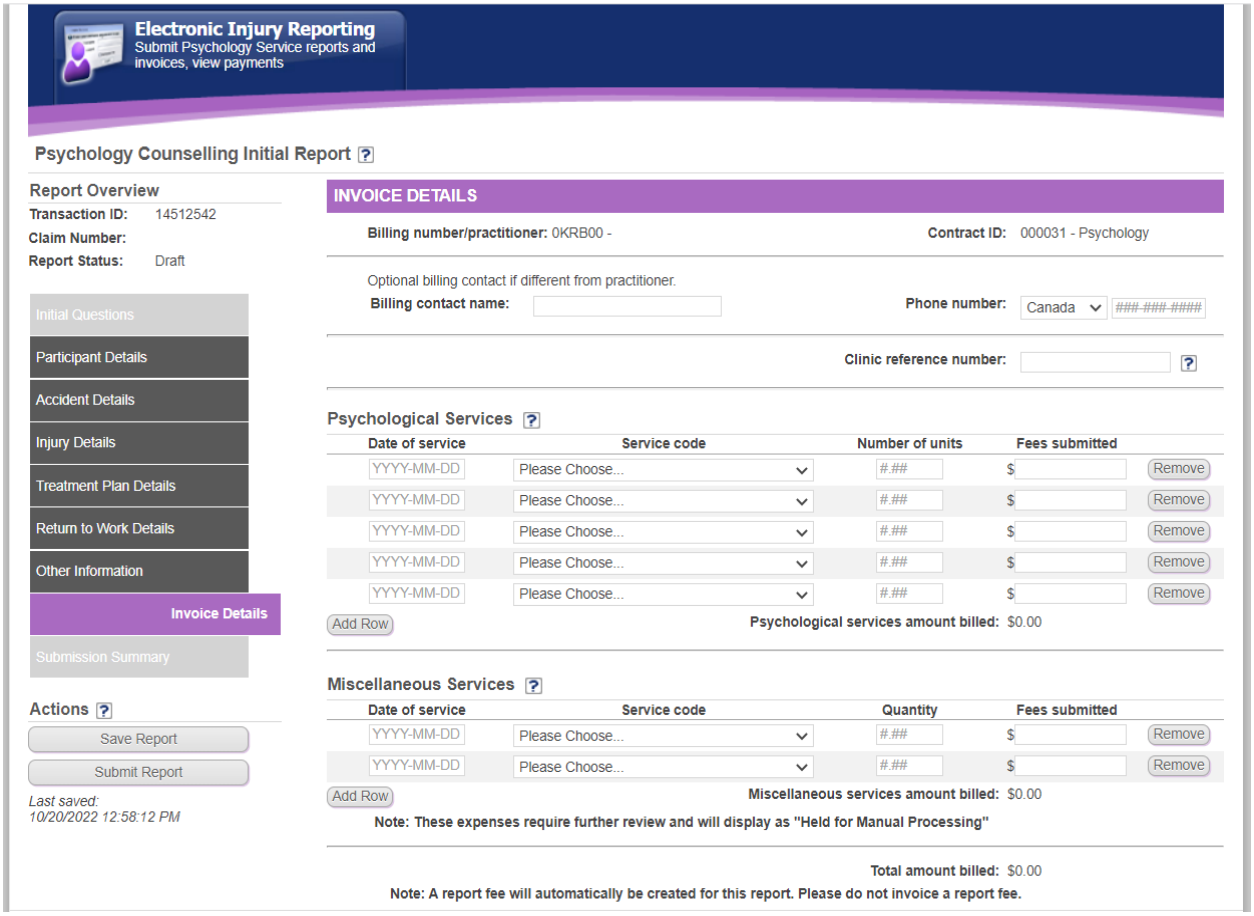
- The remove button will allow you to remove the corresponding *Attachment* fields.

Add Attachment

- Click this to add a new *Attachment type* field.

Additional comments

- This field is for you to provide any additional comments regarding other information relevant to the processing of the form.



Invoice

Billing number/practitioner

- This field will be pre-populated from the corresponding report for which the invoice is being completed.

Contract ID

- This field will be pre-populated from the report for which the invoice is being completed.
- **Note:** Use the option *to provide an alternate contact for billing* if the invoice is completed by someone other than the practitioner.

Billing contact name

- Enter the first and last name of the individual who completed the invoice.

Phone number

- Enter the billing contact's area code and phone number.
- The country field is pre-populated with Canada. A different country can be selected from the drop-down box.
- If entering or changing the country field all fields are required. Including country, area code and a seven-digit fax number (enter the fax number as ###-###-####, ##########, or (###) ###-####).

Clinic reference number

- Enter the reference number your clinic may use to identify the medical report or invoice.

Psychological Services

Date of service *

- Enter the date the psychological service was provided (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).

Service code *

- Select the appropriate service code for the service that was provided from the drop-down menu.

Number of units

- Indicate the number of units of service provided by time, size or number. For example, the number of consecutive hospitals visit days, the number of services performed, or the number of units.
- Enter the information in numeric format (e.g., 2).

Fees submitted

- This field will be pre-populated based on the service code and number of units provided.

Psychological services amount billed

This will be automatically populated as the total amount of psychological services billed.

Note:

- The *Remove* button can be used to extract any extra lines.
- Two fields are provided for dates of service. Click the *Add Row* button to add additional fields.

Miscellaneous services

Date of service

- Enter the date the miscellaneous service was provided (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2012 can be entered as 20120412).

Service code

- Select the appropriate service code for the service that was provided from the drop-down menu.

Quantity

- Enter the number/amount of the miscellaneous services.

- Enter the information in numeric format (e.g., 2).

Fees submitted
- Use this field to enter the amount for the miscellaneous services.

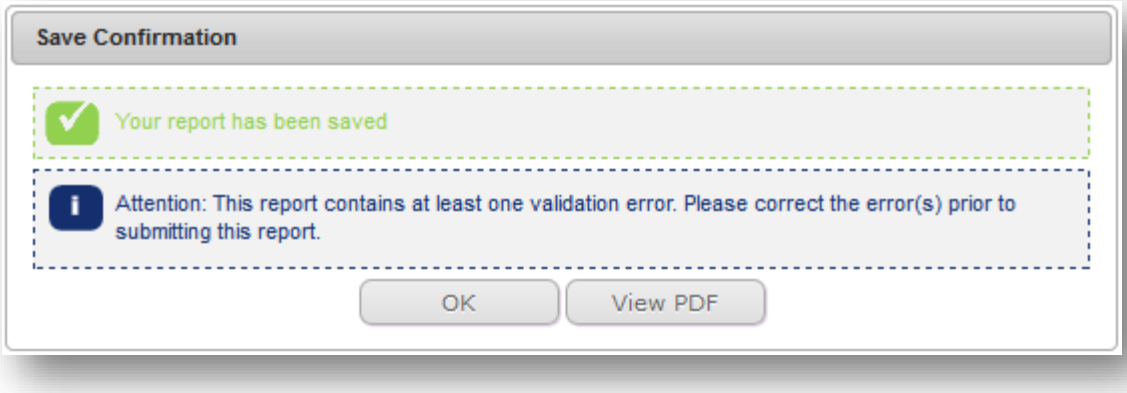
Note:
- The *Remove* button can be used to extract any extra lines.
- Fields are provided for two dates of service. Click the *Add Row* button to add additional fields.

Miscellaneous services amount billed
- This will be automatically populated as sum of all the miscellaneous services quantity * fee submitted.

Save report

- If you have signed into your account, the report will auto save as soon as the *Billing Number* and *Worker's Last Name* fields have been completed. It will continue to auto save as you complete the form. You will be able to see the last saved timestamp in the side navigation bar under the *Actions* buttons.
- To manually save a report click the *Save Report* button in the *Actions* section of the side navigation bar.
- If your report has been successfully saved, you will receive the following message:

- If you click *OK* the dialog box will close and you will be returned to the report screen.
- If you click *PDF* a draft report will open in PDF format in a new window.
- If there are errors in your report, your report will still be saved. You will be informed of the errors with the following message:

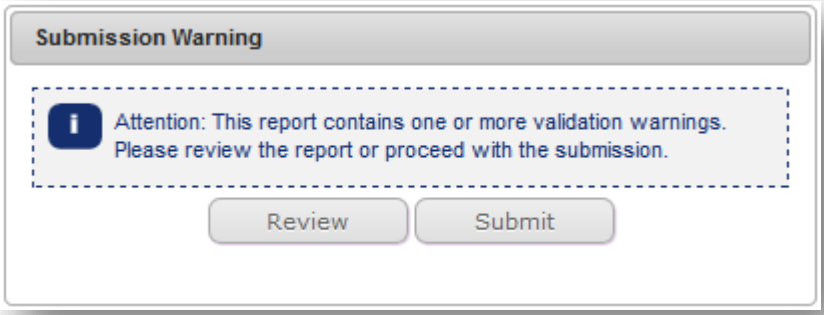


Note: Saving your report does not submit the report to the WCB. The report must be submitted by clicking the *Submit Report* button in the *Actions* section of the side navigation bar.

Submit report

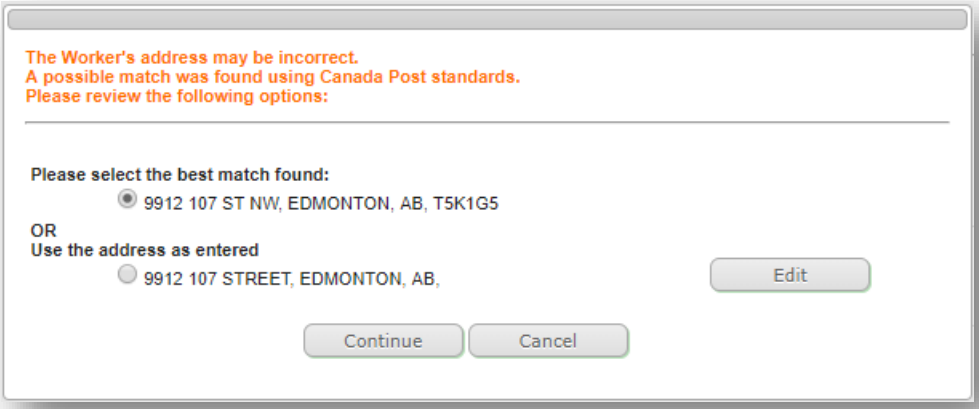
- To submit your report, click the *Submit Report* button in the *Actions* section of the side navigation bar.
- If there are no errors in your report, you will be taken to the *Submission Summary* screen.
- If your report contains errors that prevent the report from being submitted, you will receive the following message:

- Click *OK* to return to the report to fix the errors. Once the errors are corrected you can try to submit the report again.
- You may also receive a warning to review certain information. The following message will be displayed:



- Click *Review* to return to the report to review the warnings.
- Click *Submit* to submit the report in its current form.

- If the mailing address does not match Canada Post standards, you will receive a warning.



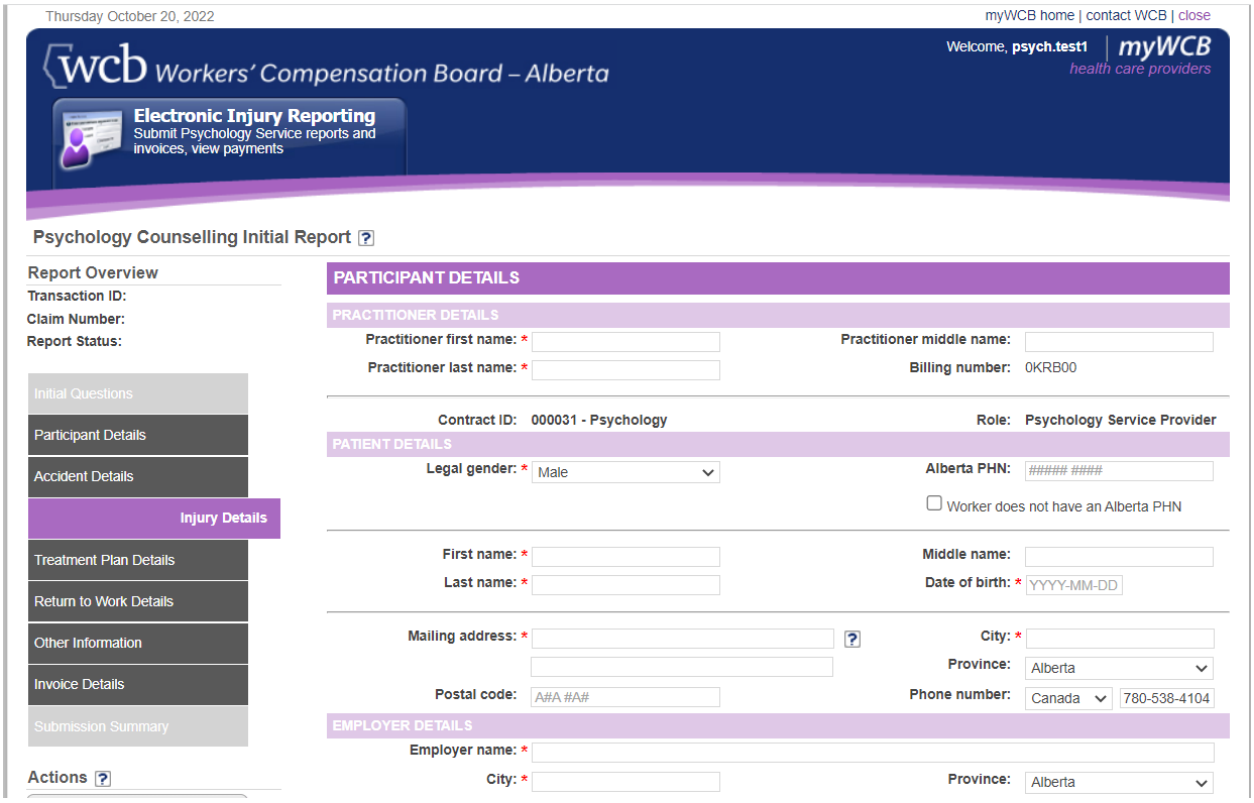
- Click *Continue* to select the best match address, when available, or chose the radio button beside the address you entered.
- Click *Edit* if you want to enter a different address.

Electronic Injury Reporting – Mental Health First Report – C1392

All Mandatory Fields are denoted by (*)

This Electronic Injury Reporting System is enabled with a show/hide function. Depending on how you answer some questions, additional fields may be available or unavailable for completion.

For example, if it is indicated that a worker has missed time from work additional information regarding the time loss is required and therefore additional fields will be visible for completion. If information is entered and the initial answer is later changed to indicate the worker did not miss time from work the additional fields will no longer be visible and any information previously entered in them will not be saved.



Participant details

- This section may be pre-populated and will display the billing number, practitioner information, the worker's Alberta PHN, name, date of birth, address and employer name.
- Selecting the *View/Modify* button will open the detailed view and allow the user to make changes.
- If there are any errors in the participant details section when the report is saved or submitted, the detailed view will automatically open allowing the user to make the required changes.

Practitioner details

- The following fields identify the practitioner who rendered treatment and may be pre-populated or require the user to enter the information:
    - Practitioner first name *,
    - Practitioner middle name, and
    - Practitioner last name*.
- The *Contract ID*, *Role* and *Billing Number* will be pre-populated and cannot be changed.

Worker details

Legal gender *

- This field may be pre-populated from previous reports.

- If not pre-populated, indicate the gender of the worker by selecting *Female, Male* or *X*.

Alberta PHN *

- Enter an Alberta Personal Health Number (the following formats are accepted ##### ####, #########, #####-####).
- If the worker does not have an Alberta PHN select the check box: *Worker does not have an Alberta PHN.* This will clear the Alberta PHN check box field.

First and last name *

- The worker's name must be a legal name and should correspond with the name associated with the PHN if provided.
- The worker's middle name should be included if provided as this will help identify the worker (this field may not be available if the worker's name was pre-populated).

Date of birth *

- Enter the worker's date of birth (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).
- A warning will occur when there is less than 12 years between the date of birth and the current date.

Mailing address *

- The worker's current street address including the unit number if applicable (e.g., # 802 11520 – 89 Avenue).
- Note, the worker's mailing address may be different from where the worker's physical address is.
- This mailing address should be where WCB can send correspondence to the worker.
- Two address lines are provided, however only line one is required.

Note: If the mailing address does not match Canada Post standards, you will receive a warning. Please select the suggested address, when available, or the address you entered. Click on *Edit* if you want to enter a different address.

City *

- Enter the city or town where the worker resides. Abbreviations will not be accepted.

Province

- The system defaults to Alberta, alternate provinces and states can be selected from the drop-down list.
- The drop-down list has a please choose option for addresses from another country.

Postal code

- Enter a valid postal code for the worker's address, (enter the postal code as L#L#L# for addresses in Canada).
- If a U.S. state is selected in the province field, enter the zip code (enter the zip code as ##### or ######-####).

Phone number

- The country field is pre-populated with Canada. A different country can be selected from the drop-down box.
- If a country code other than Canada or the U.S. is selected the country code may be automatically populated.
- Enter the worker's phone number.
- If entering a Canadian or U.S. phone number, enter the area code and a seven digit phone number (enter the phone number as ###-###-####, ##########, or (###) ###-####).
- If entering a phone number for a different country, the field will allow up to 24 characters including the country code.

Employer details

Employer name *

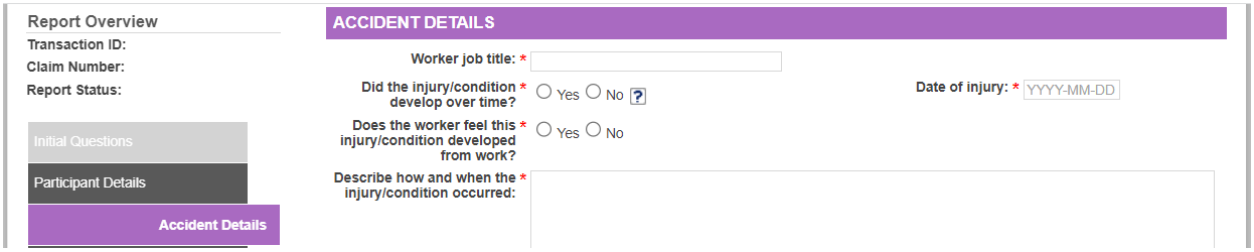
- Enter the name of the worker's employer at the time of the accident/injury.

City *

- Enter the city or town where the employer is located. Abbreviations will not be accepted.

Province

- The system defaults to Alberta, alternate provinces and states can be selected from the drop-down list.
- The drop-down list has a please choose option for addresses from another country.



Accident

Worker job title *

- This field may be pre-populated if there is a successful worker and claim match or based off previous reporting.
- If it is not pre-populated enter the position or job title held by the worker at the time of the accident/injury.

Did the injury/condition develop over time? *

- Indicate whether the injury occurred over a period of time or from a specific incident and/or distinct event.
- If the injury occurred over a period of time, select *Yes.*
- If the injury was from a distinct incident, or a specific event or accident select *No.*

Date of injury *

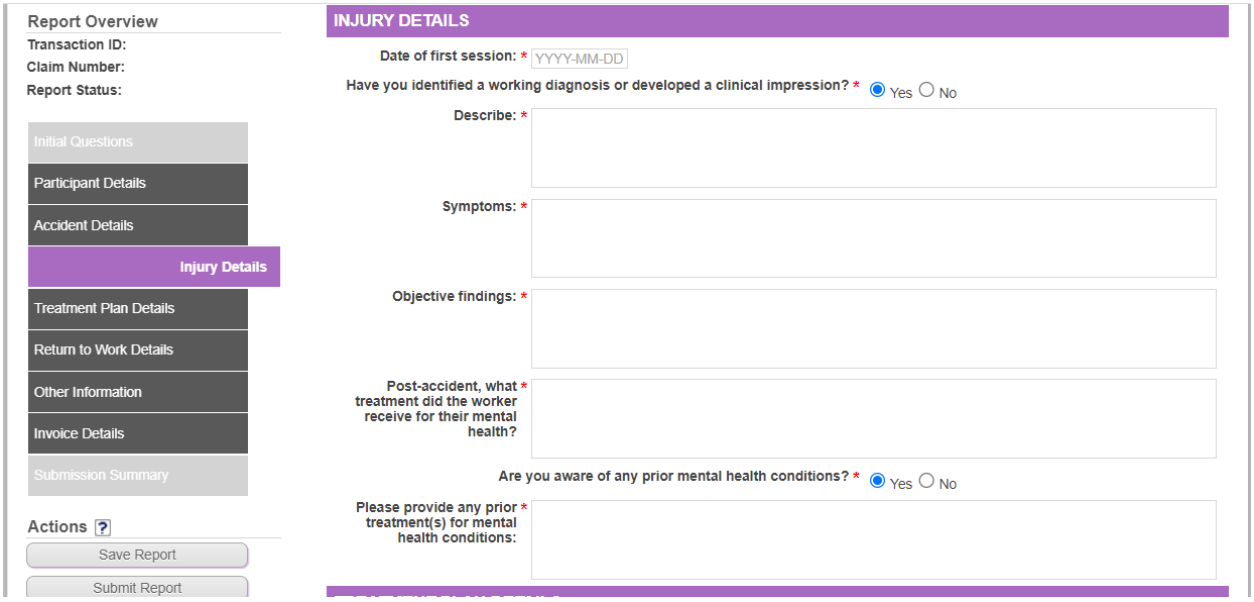
- Provide the specific date the accident occurred
- If the injury/condition developed over time, use the date that the worker first sought psych treatment (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).
- The date of injury must be on or before the current date and the difference between the date of injury and date of birth must be greater than 12 years otherwise a warning will be generated.

Does the worker feel this injury/condition developed from work? *

- Provide a description of the job duties, demands or other jobs factors, the worker believes increased or caused the symptoms.

Describe how and when the injury/condition occurred *

- Provide a description of the circumstances around the Incident and how the incident occurred.
- If the injury or condition developed over time, provide a description of the job duties and physical demands that increased or caused the symptoms.



Injury

Date of first session *

- Enter the date of first session (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).
- The date of session must be:
  - Prior to or equal to the current date,
  - Prior to or equal to the report completion date,
  - After or equal to the date of injury, and

- The difference between the date of assessment and date of birth must be greater than or equal to 12 years otherwise a warning message will be generated.

Have you identified a working diagnosis or developed a clinical impression? *

- Select Yes or *No* based on if you have identified a working diagnosis or developed a clinical impression

Describe *

- Please provide a working diagnosis or clinical impression based on a DSM-5 TR

Symptoms *

- Enter the symptoms that the worker exhibits.
- Include how the worker describes the symptoms (e.g., number of hours slept, reported mood, thought process, etc.).

Objective findings *

- Describe nature of symptoms and include things like hygiene, activities of daily living, ability to engage in functional domains, affect, etc.

Post-accident, what treatment did the worker receive for their mental health? *

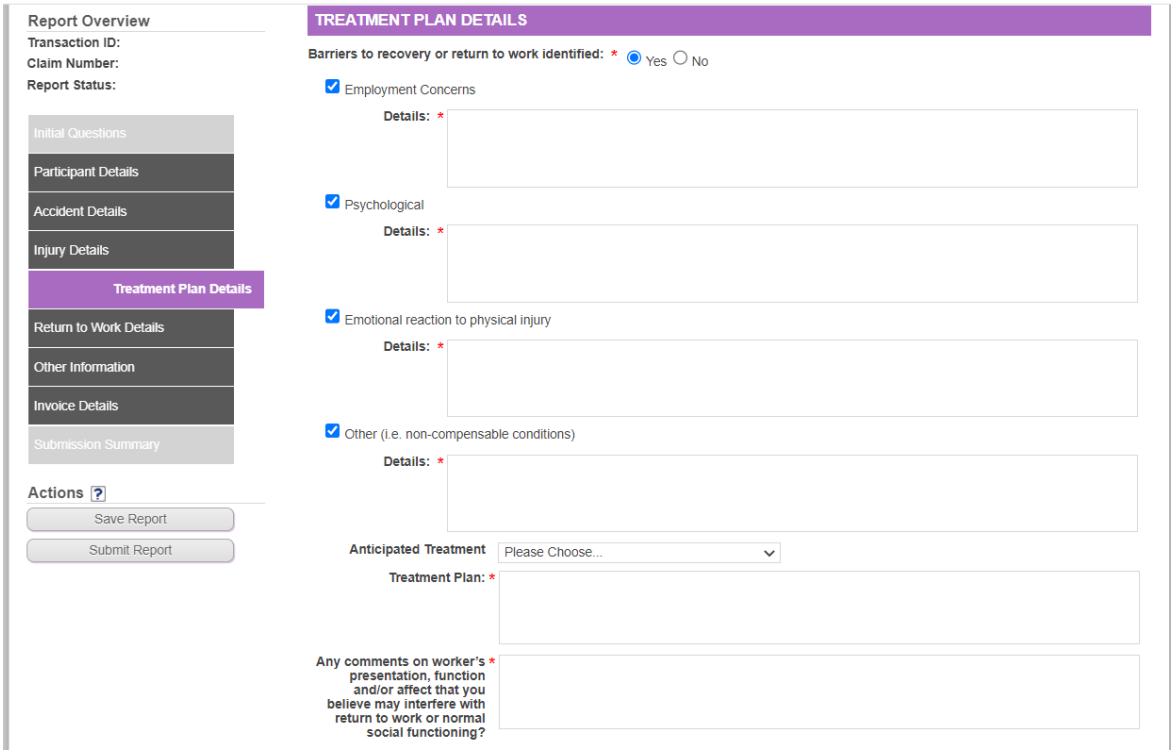
- Please provide from information found in medical package and/or provided by worker. Examples: GP, family/peer support, EAP, counselling etc.

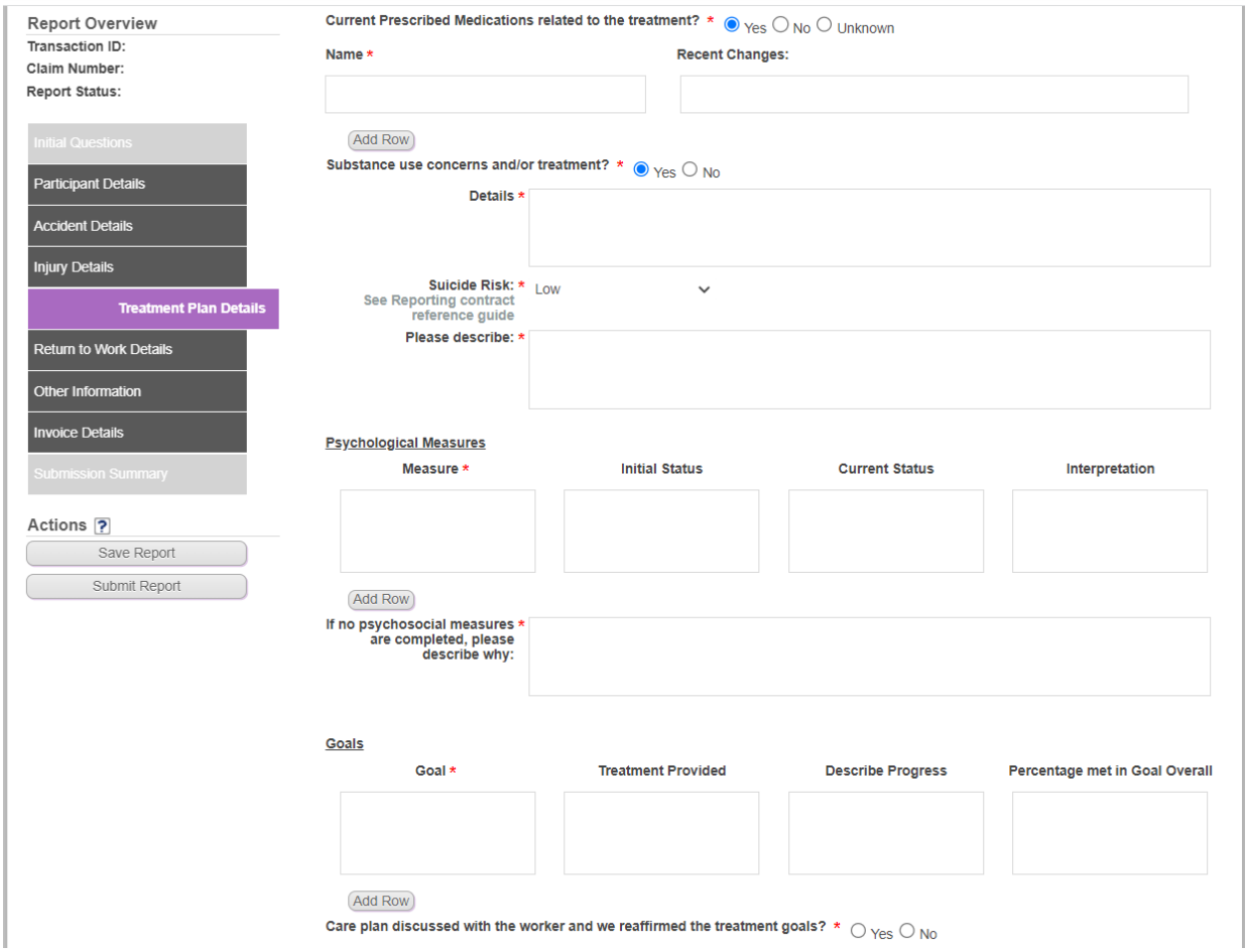
Are you aware of any prior mental health conditions? *

- Select *Yes*, if information found in medical package and/or reported by worker.
- Select *No*, if no evidence of prior mental health found in medical package and/or reported by worker.

Please provide any prior treatment(s) for mental health conditions *

- If applicable, please provide a history of past treatments for mental health condition(s)





Barriers to recovery or return to work identified? *

- Select *Yes* of *No* if there are barriers to the worker's recovery or return to work.

Employment concerns

- Select if barriers are related to the workplace.

Details *

- Provide details on barriers related to the compensable injury (e.g., not job attached, lack of appropriate modified work etc.) **or** non-compensable (dislikes/hates job, toxic work environment, feeling unsupported, burnout, interpersonal issues with management, denied vacation requests, etc.).

Psychological

- Select if barriers are psychological in nature.

Details *

- Please provide details on barriers related to psychological conditions (e.g., anxiety, avoidance, lack of sleep etc.).

Emotional reaction to physical injury

- Select if primary nature of injury is physical and injury is barrier.

Details *

- Please provide details as to how barriers are related to physical injury (e.g., pain focused).

Other (e.g., non-compensable conditions)

- Select if barriers are not related to any of the above categories.

Details *

- Please provide more information about the recovery or return to work barriers which are not listed in other categories.

Anticipated Treatment

Select one of the following anticipated treatment options from the drop-down list.

- Short term supportive counselling: If the presenting problem is estimated to be resolved in less than five sessions.
- Treatment for a psychological condition: If the presenting psychological condition is estimated to be resolved in more than five sessions of treatment.
- Counselling for family member of deceased worker: If the worker is deceased and treatment is for the worker's family member.
- Joint family counselling: If family and/or couple counselling is required to remove barrier to return to work.
- No further psychological services are required: If you are not recommending any further counselling sessions.

Treatment plan *

- Describe the proposed treatment and encouraged activities including work, daily living routine and therapy homework. Describe the outcome/goal of the treatment in relation to return to work.
- Please advise if treatment is being completed in person, virtually or a blend of both.

Any comments on worker's presentation, function and/or affect that you believe may interfere with return to work or normal social functioning? *

- If outside normal limits, describe any issues with attendance, behaviors, comprehension, emotional response, speech quality, judgment or mood. If within normal limits, please enter "no concerns with presentation".

WCB Services for consideration

Select from options, only if applicable.

Case conference with claim owner

- Select if you would like to be contacted by the WCB claim owner.

Details

- For example, a brief description of what you would like to discuss with the claim owner (e.g., modified work).

Case conference with WCB psychology consultant

- Select if you would like to be contacted by a WCB psychology consultant.

Details

- For example, a brief description of what you would like to discuss with the psychological consultant (e.g., help with goal percentage).

Interdisciplinary treatment services

- Select if the worker's issues are complex and require the support of a multidisciplinary team. If selected, counselling services would continue in a Return-to-Work Program (e.g., Complex Pain program, Traumatic Psychological Injury (TPI) program).

Details

- Provide rationale to support a multidisciplinary program.

Further assessment

- Select if you would like the claim owner to consider a more comprehensive assessment.

Details

- Describe the purpose of the proposed assessment: to help confirm diagnosis, temporary and/or permanent restrictions, return to work and/or further treatment recommendations.

Other counselling support for non-work injury related stressors/concerns

- Select if you have identified a need for a non-work-related counselling.

Details

- Specify what kind of treatment should be considered for client (e.g., grief counselling, life stressors management, etc.).

Occupational therapy

- Select if you want claim owner to consider concurrent treatment with an occupational therapist (i.e., exposure treatment).

Details

- Please provide rationale for considering the involvement of an occupational therapist to support the care plan.

Family counselling

- Select if you would like claim owner to consider counselling for worker's immediate family members.

Details

- Provide brief explanation of services to be considered.

Current Prescribed Medication related to the treatment? *

Indicate if the worker is currently under prescribed medication related to the treatment by selecting *Yes, No* or *Unknown*

Name *

- Name and/or DIN of prescribed medication(s).

Recent changes

- Any changes in dosage (e.g., from 5 mg to 10 mg).

Add Row

- If more than one medication, please add a row and follow steps above to enter information.

Substance use concerns and/or treatment? *

- Indicates if there are any substance use concerns and/or treatment by selecting *Yes* or *No*.

Details

- Please describe previous and/or current substance abuse use, current symptoms and treatment to date.

Suicide risk *

☐ No risk	☐ Low	☐ Medium	☐ High
	• No plan • No intent • No time frame • Multiple protective factors (e.g., family, friends, faith)	• Some plan • No immediate intent • Vague or distant time frame • Some protective factors (e.g., family, friends, faith)	• Active plan • Expressed intent • Access to means (e.g., pills, gun, rope, vehicle) • Imminent time frame • Minimal or limited protective factors

Please describe *

- Identify the unique risk and protective factors, individuals may have different responses to the same stressor or protective factor. Identification may help with future care planning. Please outline any risk factors and protective factors.

- If required, please outline a risk management plan. If a worker has suicidal or homicidal ideation, has a plan, and you believe they or others are at immediate risk, please follow your office emergency procedures, which may include calling 911 or mobile crisis. Please call and inform WCB once the emergency has been stabilized.

Psychometric table

Measure *

- Please provide at least one psychological measure (e.g., BDI, BAI, HADS or PDI).

Initial status

- Document the psychometric tool baseline.

Current status

- Document the psychometric tool current status.

Interpretation

- Please provide interpretation of the updated psychometric measures for example GAD 7, initial 14 (moderate), current 16 (moderate), interpretation - anxiety score increased slightly.

Add row

- If more than one psychometric measure used, please add a row and follow steps above.

If no psychosocial measures are completed, please describe why *

- If you did not complete any psychosocial measures, please provide rationale.

Goals table

Goal *

- Goals that will be worked on during treatment (e.g., return to work, reduce anxiety symptoms).

Treatment provided

- Please provide treatment method or modality (CBT, supportive counselling and return to work planning).

Describe Progress

- Indicate stage of progress reached during the reporting period based on your clinical opinion, observations and objective measures.

Percentage met in goal overall

- Include a best estimate of how much of the goal has been met, as a percentage. For clinical support for how to determine the percentage, contact the WCB psychology consultants.

Add row

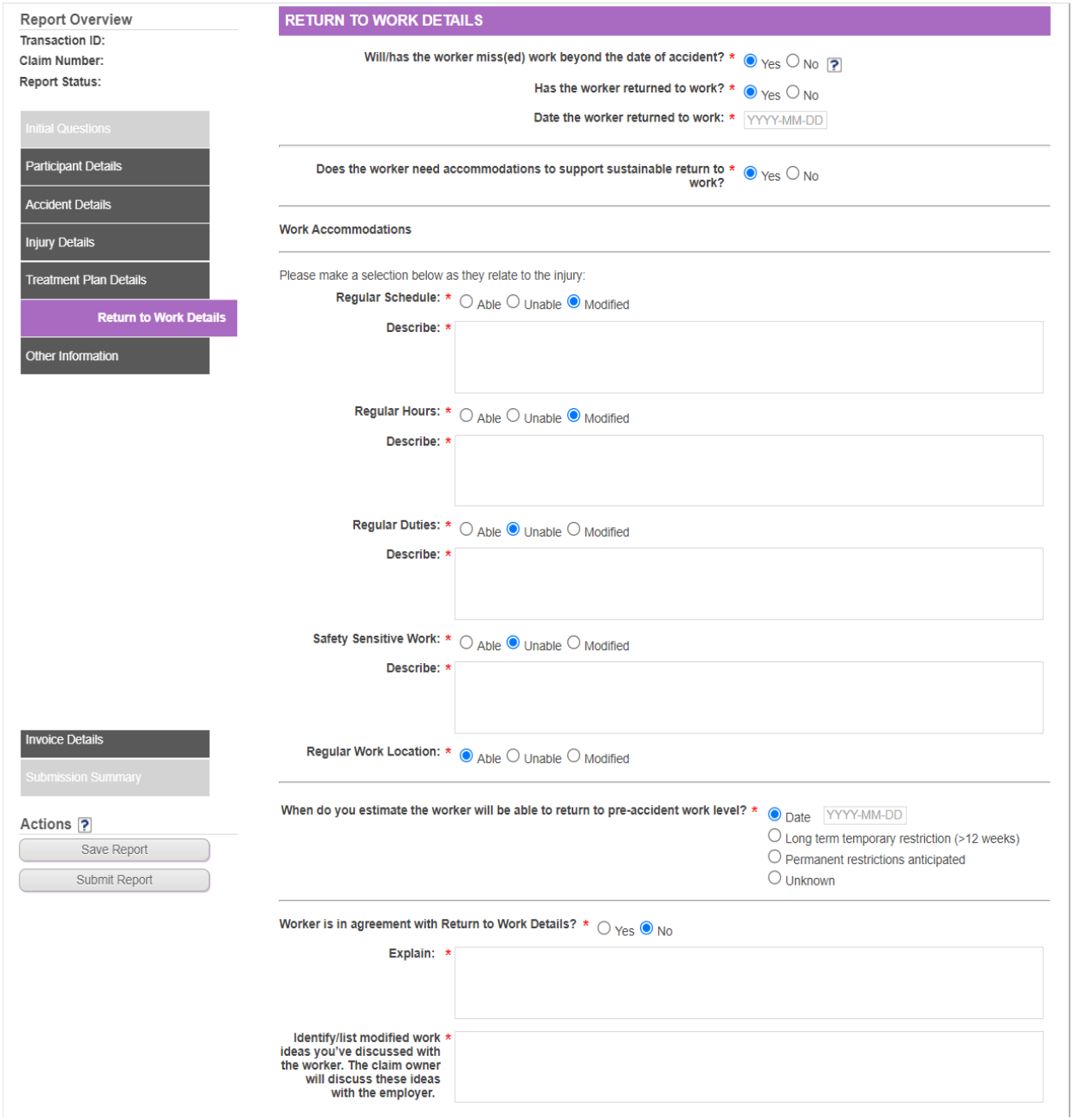
- If more than one goal provided, please add a row and repeat steps above.

Remove

- If goal added in error, use this button to remove from report.

Care plan discussed with the worker, and we reaffirmed the treatment goals? *

- Indicates if the care plan was discussed with the worker and the treatment goals were reaffirmed by selecting *Yes* or *No*.
- Please describe how you plan to taper counselling support as progress made



Return to work

Will/has the worker missed work beyond the date of accident? *

- Answer *no* to this question if:

  - The worker is able to perform regular or modified duties, or
  - The worker is absent from work to attend medical appointments but continues to work except for these appointments.

Answer *yes* if the worker has missed or will miss time beyond the date they were injured at work.

Has the worker returned to work? *

- Select *Yes* or *No.*

Date the worker returned to work. *

- Enter the date the worker returned to work after their injury (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).

Does the worker need accommodations to support sustainable return to work? *

- Select *Yes* if a work accommodation will help maintain return to work in any capacity and/or support a return-to-work plan.
- Select *No* if worker will do well completing regular duties and schedule, no accommodations required.

Regular schedule (work accommodations) *

- (pre-accident work schedule, M-F 8 a.m. – 4 p.m.).
- Select *Modified* if a change in work schedule will help worker return to work.
- Select *Able* if worker is able to work pre-accident schedule.
- Select *Unable* if worker is unable to work due to psychological injury.

Describe (regular schedule) *

Please provide date of accident schedule and proposed new schedule. If a gradual return to work would work best, please provide detailed plan (e.g., moving rRegular schedule M-F 12-hour shifts to M-F 8 hours per day).

Regular hours (work accommodations) *

- (e.g., 8-hrshift,12-hrshift).
- Select *Modified* if a change in work hours will help worker return to work.
- Select *Able* if worker is able to work pre-accident hours.
- Select *Unable* if worker is unable to work due to psychological injury.

Describe (regular hours) *

- Please provide date of accident hours and proposed new hours. If a gradual return to work would work best, please provide detailed plan (e.g., Regular schedule M-F 8-4, proposed schedule M-F, 8-12 for two weeks increasing to 8-2 in week three, returning to regular hour 8-4 in week).

Regular duties (work accommodations) *

- Based on job description, physical demands analysis and/or worker's description.
- Select *Modified* if a change in regular work duties will help worker return to work. Select *Able* if worker is able to work pre-accident duties. Select *Unable* if worker is unable to work due to psychological injury.

Describe (regular duties) *

- Please provide date of accident job and proposed new duties. If a gradual return to work would work best, please provide a detailed plan (e.g., administrative assistant, proposed changes in duties - work from home, no contact with public for one month).

Safety sensitive work (work accommodations) *

- Add tasks that require complex thought, actions and/or work typically considered hazardous.
- Select Modified if accommodating for sensitive work duties will help worker return to work.
- Select Able if worker is able to work pre-accident duties and schedule.
- Select unable if worker is unable to work due to psychological injury.

Describe (safety sensitive work) *

- Please provide rationale and time frame expected this will last (e.g., medication doesn't allow cognitive difficulties due to psychological injury - will monitor for a month and update as required).

Regular work location (work accommodations) *

- *Regular Work Location* (pre-accident work location).
- Select *Modified* if accommodating an alternative workspace will help worker return to work.
- Select Able if worker is able to work at pre-accident work location.
- Select *Unable* if worker is unable to work due to psychological injury.

Describe (regular work location) *

- Please provide rationale as to why worker cannot work in their regular workspace. (e.g., work from home due to bulling and harassment at work - monitor one month and update in next reporting).

When do you estimate the worker will be able to return to pre-accident work level? *

- Enter the date that you expect the worker will be able to return to their regular work with no accommodations required (use the calendar by clicking in the date field or enter the date in the YYYYMMDD, YYYY-MM-DD or YYYY/MM/DD format, e.g., April 12, 2022 can be entered as 20120422).
- If it is estimated the worker will not be able to return to their regular work duties in near future or permanently, select *long term temporary restrictions or Permanent restrictions anticipated*.

If uncertain of when worker will be able to return to full duties and hours, and/or if there will be temporary or permanent restriction, choose Unknown

Worker is in agreement with Return-to-Work Details? *

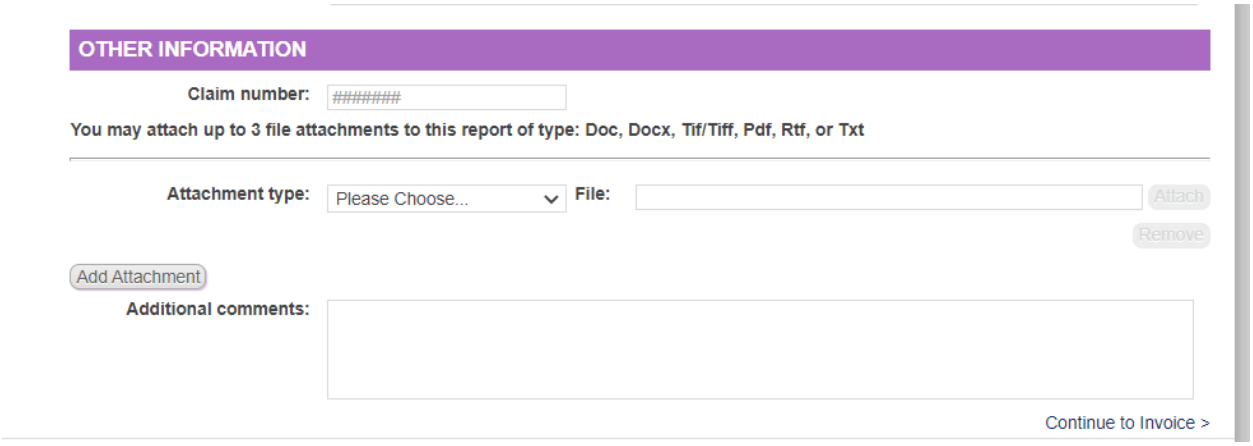
- Indicate if the worker agrees with return-to-work details by selecting Yes or No.

Explain: *

- If *yes* is selected - explain the plan the worker is in agreement with (e.g., gradual return to work plan, week one regular duties, 8 a.m. - 12 p.m. Mon-Fri, week two return to regular duties and hours)
- If *no* is selected - explain what the worker does not agree with, their rationale and your clinical guidance. For example, worker does not agree that they can work Mon-Fri as they think the anxiety will be overwhelming. You discussed the strategies to use when feeling overwhelmed at work – taking breaks, grounding etc. and reminded worker plan can be adjusted.

Identify/list modified work ideas you've discussed with the worker. The claim owner will discuss these ideas with the employer.

- Clarify list/ideas for modified work to be discussed with employer to ensure a safe and timely return to work for the worker.



Other Information

This section shows additional questions that are not in any other sections.

Claim number

- This field may be pre-populated based on previous reports.
- If not pre-populated, enter a claim number in for which the form is being submitted.

Note: You may attach up to three file attachments to this report of type: DOC. DOCX, TIFF, PDF, RTF or TXT.

Attachment type

- Select *Additional information* from the drop-down box.
- When *Attachment type* is selected, the *File* and *Browse* fields are available.

File

- This is the address of the attachment file you would like to upload.

- If the attachment type is populated, then the file must also be completed.

Browse

- Click to open a standard browse file dialog to allow you to choose a file from your computer.
- If you select a file from the browse button, this will automatically populate the file address field.

Remove

- The remove button will allow you to remove the corresponding *Attachment* fields.

Add Attachment

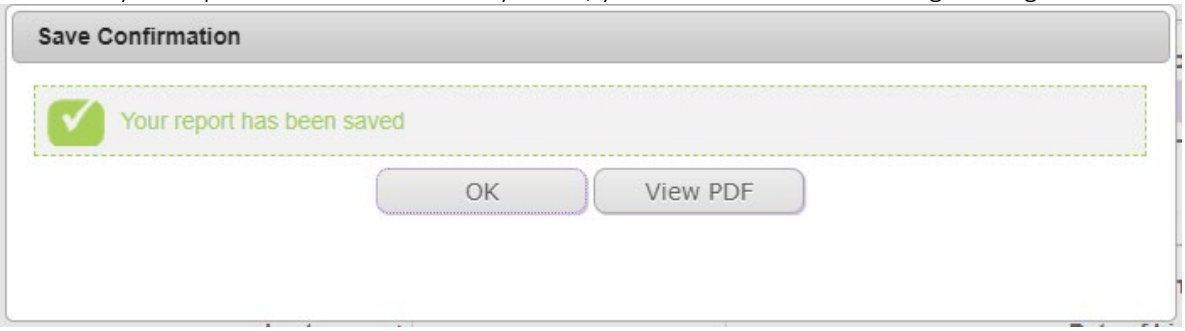
- Click this to add a new *Attachment type* field.

Additional comments

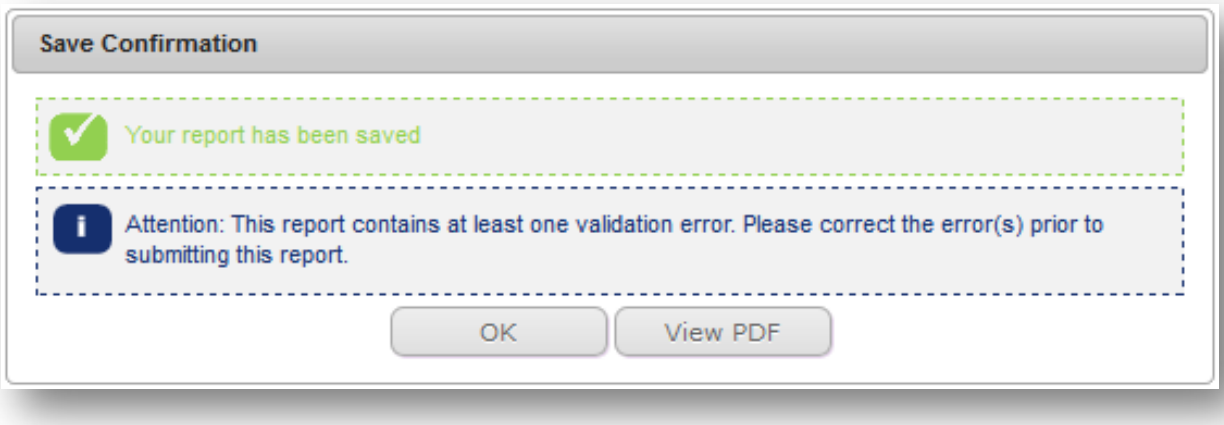
- This field is for you to provide any additional comments regarding other information relevant to the processing of the form.

Save Report

- If you have signed into your account, the report will auto save as soon as the *Billing Number* and *Worker's Last Name* fields have been completed. It will continue to auto save as you complete the form. You will be able to see the last saved timestamp in the side navigation bar under the *Actions* buttons.
- To manually save a report click the *Save Report* button in the *Actions* section of the side navigation bar.
- If your report has been successfully saved, you will receive the following message:



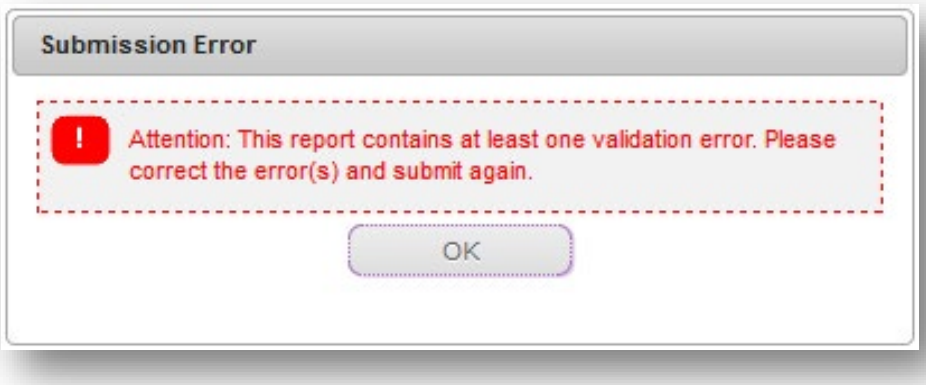
- If you click *OK* the dialog box will close and you will be returned to the report screen.
- If you click *PDF* a draft report will open in PDF format in a new window.
- If there are errors in your report, your report will still be saved You will be informed of the errors with the following message:



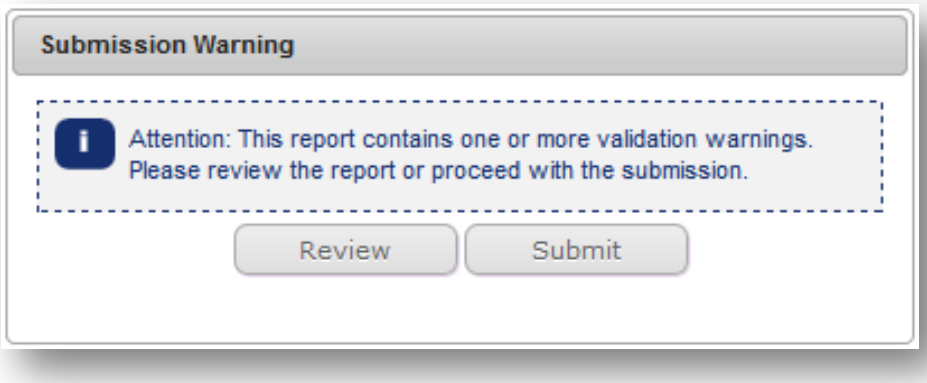
Note: Saving your report does not submit the report to the WCB The report must be submitted by clicking the *Submit Report* button in the *Actions* section of the side navigation bar.

Submit Report

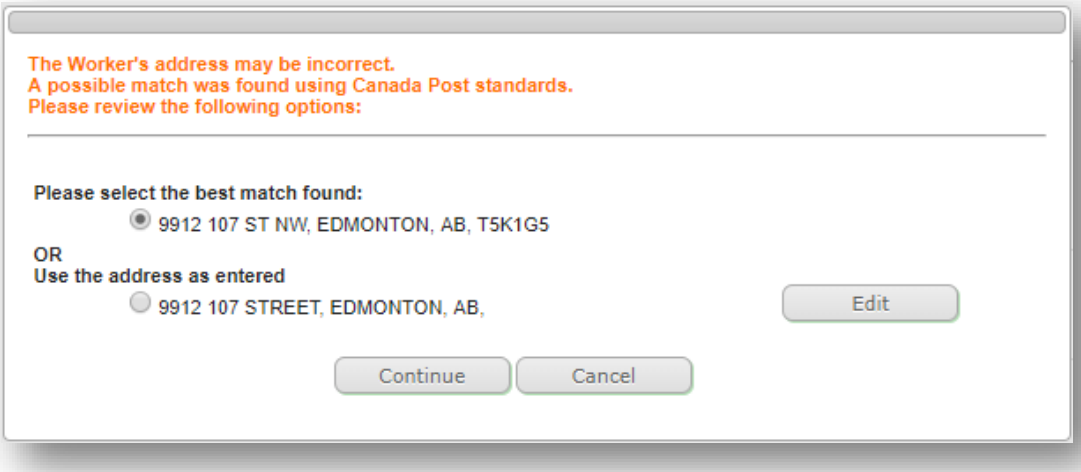
- To submit your report, click the *Submit Report* button in the *Actions* section of the side navigation bar.
- If there are no errors in your report, you will be taken to the *Submission Summary* screen.
- If your report contains errors that prevent the report from being submitted, you will receive the following message:



- Click *OK* to return to the report to fix the errors.. Once the errors are corrected you can try to submit the report again.
- You may also receive a warning to review certain information. The following message will be displayed:



- Click *Review* to return to the report to review the warnings.
- Click *Submit* to submit the report in its current form.
- If the mailing address does not match Canada Post standards, you will receive a warning.



- Click *Continue* to select the best match address, when available, or chose the radio button beside the address you entered.
- Click *Edit* if you want to enter a different address.