wcb Workers' Compensation Board – Alberta

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C851
PSYCHOLOGY SERVICES
Counselling Initial Report

WORKER DETAILS

Surname	First Name and Initial	Legal Gender	WCB Claim Number
Jones	Adam W.	☐ Female ☐ Male	123 4567
Address	**City/Town**	**Province / Postal Code**	**Date of Birth** *(yyyy/mm/dd)* / **Worker Telephone Number**
			1987/12/24

EMPLOYER DETAILS

Employer Name	City	Province

Service Delivery

☐ In Person ☐ Virtual*

**For sessions completed via telehealth, informed verbal consent was obtained from this Worker to communicate care using virtual care and other communication tools. This Worker has been explained the risks related to unauthorized disclosure or interception of personal health information and steps they can take to help protect their information.*

Purpose of report:

To report the findings from the initial counseling session. In this report, you will determine the need for psychological services, indicate the worker's current psychological status, and identify barriers to healthy psychological functioning and/or return to work. You will also create a treatment plan, including a baseline for psychosocial measures and goals.

Reporting expectations:

1. The counselling initial report must be completed using the **C851** template. Reports must be type-written and signed by the treating clinician.
2. The fee for submitting this report will depend on the number of days between the initial counselling session and report submission (check the appropriate box on the last page).
3. The report will address the criteria outlined below, as well as any specific issues or questions identified by the Claim Owner (if applicable).

ACCIDENT DETAILS

Worker's Job Title/Occupation:	Date of Injury *(yyyy/mm/dd)*

Did the injury/condition develop over time?	Does the worker feel the injury/condition developed from work?
☐ Yes ☐ No	☐ Yes ☐ No

Describe how and when the injury/condition occurred:

INJURY DETAILS

Referral date *(yyyy/mm/dd)*	Initial Counselling Session Date *(yyyy/mm/dd)*	Report Date *(yyyy/mm/dd)*

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

Commented [CD1]: A 7-digit number that identifies the worker's WCB claim file.

Commented [CD2]: Date pickers can be used to fill dates in a consistent format

Commented [CD3]: Select the appropriate box for the service delivery method.

If providing service virtually, please follow the CAP's guidelines for obtaining informed verbal consent.

Commented [CD4]: Answer is based on your clinical opinion.
- 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***.

Commented [CD5]:
- Provide a description of the circumstances around the incident and how the incident occurred.
- If worker believes condition developed from work, provide a description of the job duties, demands or other jobs factors, the worker believes increased or caused the symptoms.
- If the injury or condition developed over time, provide a description of the job duties and/or physical demands that increased or caused the symptoms.

Commented [CD6]: Referral Date: Date referral letter was received by provider.

Commented [CD7]: Report Completion Date: Date report was completed; should match date entered on last page in billing section.

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Have you identified a working diagnosis or developed a clinical impression? ☐Yes ☐No

Describe: Please provide a working diagnosis or clinical impression based on DSM-5 TR
Symptoms: Enter the symptoms that the worker exhibits and include how the worker describes the symptoms (e.g., number of hours slept, reported mood, thought process, etc.)
Objective findings: 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? Provide 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? ☐ Yes ☐ No

Please provide any prior treatment(s) for mental health conditions: If applicable, please provide a history of past treatments for mental health condition(s)

Commented [CD8]: 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.

TREATMENT PLAN

Barriers to recovery or return to work identified: ☐Yes ☐No

Only check off those that apply and provide a brief description:

☐ Employment Concerns Provide details on how barriers are related to the compensable injury (e.g., not job attached, lack of appropriate modified work etc.) **or** non-compensable (interpersonal issues/relationships, job satisfaction, work environment (feeling unsupported, burnt out), interpersonal issues, performance concerns etc.)
☐ Psychological Provide details as how barriers are related to psychological condition (e.g., anxiety, avoidance, lack of sleep etc.).
☐ Emotional reaction to physical injury Provide details as to how barriers are related to physical injury (e.g., pain focused).
☐ Other (i.e., non-compensable conditions) Provide more information about the recovery or return to work barriers not listed in other categories.
Explain: Use this box to explain barriers chosen in the above categories.

Commented [CD9]: Select if barriers are related to the workplace.

Commented [CD10]: Select if barriers are psychological in nature.

Commented [CD11]: Select if primary nature of injury is physical and injury is barrier.

Commented [CD12]: Select if barriers are not related to any of the above categories.

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Anticipated Treatment: Choose an item.

☐ Short term supportive counselling
If the presenting problem is estimated to be resolved in less than 5 sessions

☐ Treatment for a psychological condition
If the presenting psychological condition is estimated to be resolved in more than 5 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: Add frequency of session (weekly, bi-weekly, monthly) and 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.

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".

Commented [CD13]: Select one of the following anticipated treatment options from the drop-down menu.

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 to discuss claim issues.

☐ Case conference with WCB psych consultant Select if you would like to be contacted by a WCB psychological consultant to discuss clinical issues.

☐ 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)*. Provide rationale to support a multidisciplinary program.

☐ Further Assessment Select if you would like the claim owner to consider a more comprehensive assessment. Describe the purpose of the proposed assessment: to help confirm diagnosis, temporary and/or permanent restrictions, return to work, and/or further treatment recommendations.

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☐ Other counselling support for non-work injury related stressors/concerns Select if you have identified a need for non-work-related counselling. Specify what kind of treatment should be considered for the worker (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). 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 a worker's immediate family member.

Describe: Provide brief explanation of services to be considered.

CURRENT PRESCRIBED MEDICATION

Indicate if the worker is currently under prescribed medication related to the treatment
☐ Yes ☐ No ☐ Unknown

Complete the table as per the example:

Name	Recent Changes
Zoloft	No new changes/dose stable
Synthroid	Just started – monitoring

Commented [CD14]: Name and/or DIN of prescribed medication(s)

Commented [CD15]: Any changes in dosage (e.g., from 5mg to 10mg).

Commented [CD16]: Delete any unused rows.

Substance Use concerns and/or Treatment: ☐ Yes ☐ No

Please describe any substance use concerns and current symptoms/treatment to date.

Suicide Risk

Does the worker have suicidal or homicidal ideation? If yes, do they have a plan?

Check the most appropriate box:

☒ 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

Identify the unique risk and protective factors below. Individuals may have different responses to the same stressor or protective factor. Identification may help with your assessment and also any future care planning.
If any risk identified, please outline any risk factors and protective factors. If required, please outline a risk management plan

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If the 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.

Psychosocial Measures *(must include at least one - e.g., BDI, BAI, HADS)*

It is essential that psychosocial measures are updated on a regular basis. If needed, the WCB Psychology Consultants are a clinical resource to help you determine if a particular tool is appropriate for your client.

A minimum of one psychosocial measure must be completed based on the client's presenting problems; examples may include but are not limited to:

a. Beck Depression Inventory
b. Beck Anxiety Inventory
c. Hospital Anxiety and Depression Scale
d. Pain Disability Index

Document the psychometric tool and worker results with interpretation, as per the example:

Psychometric Tools (measure)	**Initial Status**	**Current Status**	**Interpretation**
Pain Disability Index	20-30/70	50/70	Moderate
GAD 7	4 or less	14	Moderate anxiety

If no psychosocial measures are completed, please describe why:

Set goals for treatment as per the example:**Goal**	**Treatment Provided**	**Describe Progress**	**Percentage met in goal overall**
Return to work	Supportive counselling and return-to-work planning	We are actively planning for return to work	20%
Reduce symptoms of anxiety and pain	CBT	Making objective improvements	10%

Care plan discussed with the worker and reaffirmed the treatment goals? ☐ Yes ☐ No

Please describe how you plan to taper counselling support as progress made

Commented [CD17]: Document the psychometric tool baseline

Commented [CD18]: Document the psychometric tool current status

Commented [CD19]: Delete any unused rows

Commented [CD20]: Use drop-down menu to select the baseline stage of return-to-work planning.

Commented [CD21]: Indicate stage of progress reached during the reporting period based on your clinical opinion, observations, and objective measures.

Commented [CD22]: 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.

Commented [CD23]: Delete any unused rows.

RETURN TO WORK DETAILS

Will/has the worker miss(ed) work beyond the date of accident? ☐ Yes ☐ No

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.

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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? ☐ Yes ☐ No
If yes, date the worker returned to work:

Does the worker need accommodations to support sustainable return to work? ☐ Yes ☐ No
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.

Commented [CD24]: 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 20220412).

Please make a selection as they relate to the injury:

Regular Schedule (pre-accident) Choose an item.
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.

Regular Hours (e.g., 8hrs/shift,12hrs/shift) Choose an item.
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.

Regular Duties (Based on worker's description) Choose an item.
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.

Safety Sensitive Work (Tasks that require complex thought and/or actions, and/or typically considered hazardous) Choose an item.
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.

Regular Work Location (pre-accident work location) Choose an item.
Select Modified if accommodating an alternative work space 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 accommodations made for any modified duties selected above:

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., Regular M-F 12 hour shifts moving to M-F 8 hours/day)

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 2 weeks increasing to 8-2 in week 3, returning to regular hours 8-4 in week 4).

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).

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).

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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 & harassment at work - monitor 1 month and update in next reporting)

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: If ***yes*** is selected - explain the plan the worker is in agreement with (e.g., gradual return to work plan, week 1 regular duties, 8:00a.m.-12:00pm. Mon-Fri, week 2 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.

Describe: clarify list/ideas for modified work to be discussed with employer to ensure a safe and timely return to work for the worker

Name and Mailing Address to Whom Fee is Payable	WCB Billing Number
Thera Pista 123 Rainbow Lane Cloud, AB T1T 1T1	0XY000
	Report Completion Date *(yyyy/mm/dd)*
	☐ Timely Initial Report Fee **(PPMR11A) ≤ 7 business days from initial session to report submission** ☐ Late Initial Report Fee **(PPMR11B) > 7 business days from initial session to report submission**
Telephone Number 780-123-4567	Provider's Reference Number *(optional)*
Fax Number/Email Address 587-765-4321	Provider Signature Signature of clinician who provided the counselling service (not a supervising clinician, or other office staff). A digital signature may be inserted here.

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Commented [CD25]: Use the calendar by clicking in the date field or enter the date.

Enter the date that you expect the worker will be able to return to their regular work with no accommodations required.

Commented [CD26]: 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.

Commented [CD27]: If uncertain of when worker will be able to return to full duties and hours, and/or if there will be temporary or permanent restrictions choose unknown.

Commented [CD28]: Must be name and address of payment recipient.

Commented [CD29]: Treating clinician's individual billing number. 6 characters long.

Commented [CD30]: Matches date under injury details.
Use the calendar by clicking in the date field or enter the date.

Commented [CD31]: Check the appropriate box to receive payment for report submission. Fee is based on number of business days from date of initial counselling session to date report is received by WCB.

Commented [CD32]: ***Optional*** **–**personal designated registration number or system reference number

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