Counselling Progress Report

HEALTH PROFESSIONAL INFORMATION			
Counsellor Name:			
Vendor Number:		**Telephone Number:**	

WORKER DETAILS			
Surname:		**First Name**	
Date of Birth:		**Claim Number:**	
Date of First Visit:		**Date of Injury:**	
Progress Report Completion Date:		**Service Delivery:**	◯ **In-Person** ◯ **Virtual** ◯ **Combination**

CLINICAL ASSESSMENT
Please provide an overview of the treatment modalities and interventions provided to date, including worker's progress and response (please note any changes in presentation or treatment plan since the initial assessment):

What is the current DSM Diagnosis?

Please list current medications being taken, as reported by the worker:

Substance Use and Treatment: *Please describe current substance use, symptoms and treatment to date, if applicable.*

Suicide Risk

◯ No Risk ◯ Low ◯ Medium ◯ High

If any risk identified, please outline any risk factors and protective factors. If required, please outline a risk management plan.

TREATMENT DETAILS	
Requested Number of Sessions:	
Number of sessions provided to date:	
Frequency of Sessions:	◯ Weekly ◯ Bi-Weekly ◯ Other

If checked Other, please explain

Please provide a rationale on how these additional sessions will benefit the worker and describe planned treatment modalities and interventions:

Please state if a referral to other services is required and provide explanation below (i.e., Psychiatry, OT support, etc.):

RETURN TO WORK PLAN

Return to work is an important component of a treatment plan. Please comment on worker's ability to return to work as noted below:

RTW with no restrictions:	◯ Yes ◯ No

RTW with restrictions and supports; please explain below:

If RTW with restrictions, do you recommend an occupational therapy assessment?	◯ Yes ◯ No

If unable to RTW in any capacity, please explain below:

Please comment on worker's presentation, functioning, and/or affect that you believe may present a barrier with treatment outcomes, return to work or normal social functioning?

Please describe the worker's confidence level and desire to return to work or remain at work?

Name:_____

Signature:_____

Date:_____