WorkplaceNL

Fax form to:
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Visit us at:
workplacenl.ca

Call us at:
t 709.778.1000
t 1.800.563.9000

INITIAL COUNSELLING REPORT

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

WORKER DETAILS			
Surname:		**First Name**	
Date of Birth:		**Claim Number:**	
Referral Date:		**Initial Counselling Session Date**	
Report Completion Date:		**Date of Injury:**	
Service Delivery:	◯ **In-Person** ◯ **Virtual** ◯ **Combination**		

CLINICAL ASSESSMENT
Briefly describe the presenting problem as discussed with the worker and any treatment provided to date.

Has worker received a DSM diagnosis? If yes please explain.

If completed, please identify Psychosocial Measures related to workers current DSM diagnosis, (i.e., Anxiety and Depression Scales, Trauma Recovery Scale, PCL-5, etc.)

Psychometric Tool	Normal Range	Results and Interpretation

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

Substance Use and Treatment: *Please describe previous and current substance use, current 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.

Any Pre-existing Mental Health Conditions:	◯ Yes ◯ No

If yes, please describe pre-existing history, DSM Diagnosis, and the treatment/status reported by worker:

TREATMENT PLAN

Expected Total Number of Sessions:	
Frequency of Sessions:	◯ Weekly ◯ Bi-Weekly ◯ Other

If checked Other, please explain:

Please 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? *Please describe any factors or barriers that my impact these levels to support sustained return to work, i.e. employer supports, job factors, etc.*

Name:_____

Signature:_____

Date:_____