WorkplaceNL

**Fax form to:**
709-738-1479
**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**<br>*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:_____