



Counselling Initial Report



If applicable, please select the Lock button before submitting the form.
Please note: once the Lock button has been selected, the form will no longer be editable.

INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

CLIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER

Assessment Date(s)

DATE (dd/mmm/yyyy)	DATE (if applicable) (dd/mmm/yyyy)	DATE (if applicable) (dd/mmm/yyyy)	DATE (if applicable) (dd/mmm/yyyy)
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Work Status

	PRE-ACCIDENT EMPLOYMENT/TRAINING	PRE-ACCIDENT STATUS	CURRENT EMPLOYMENT/TRAINING	CURRENT STATUS
PRIMARY STATUS				
SECONDARY STATUS				
TERTIARY STATUS				

Comments

PROVIDE ADDITIONAL COMMENTS ON STATUS OF OCCUPATION, AS RELEVANT:

Return to Work Planning

Only fill this section, "Return to Work Planning", if the client was gainfully employed on the date of the crash and is not currently working, or working for modified hours/duties.

1. WHAT IS THE CLIENT'S CURRENTLY RECOMMENDED RETURN TO WORK STATUS? <input type="radio"/> Full work status <input type="radio"/> Modified work <input type="radio"/> Not recommended to return to work in any capacity
IF MODIFIED WORK, SPECIFY WHAT MODIFICATION: <input type="checkbox"/> Modified hours <input type="checkbox"/> Modified duties
If the client is not recommended to return to work in any capacity, fill out Question 2
2. RECOMMENDATION(S) ON RETURN TO WORK

Chief Complaints

IDENTIFY CURRENT SYMPTOMS (include psychosocial, cognitive and physical symptoms as relevant):

Functional Status at the Time of the Accident

Identify if the following functional areas have been impacted by the accident.

3. UNDERSTANDING AND COMMUNICATION (cognition)

Yes No

IF YES, PROVIDE COMMENTS:

4. FUNCTIONAL MOBILITY (at home and in the community)

Yes No

IF YES, PROVIDE COMMENTS:

5. SELF-CARE (e.g. hygiene, dressing, eating)

Yes No

IF YES, PROVIDE COMMENTS:

6. SOCIAL INTERACTION

Yes No

IF YES, PROVIDE COMMENTS:

7. PRODUCTIVITY AND LEISURE (e.g. domestic responsibilities, leisure, work, school)

Yes No

IF YES, PROVIDE COMMENTS:

8. COMMUNITY INTEGRATION

Yes No

IF YES, PROVIDE COMMENTS:

History of Present Illness

9. ARE THERE RELEVANT PRE-ACCIDENT MENTAL HEALTH OR SUBSTANCE ABUSE CONCERNS?

Yes No

IF YES, PROVIDE COMMENTS:

Current Observed Findings

Comment on client's presentation (as relevant)

10. IS THE CLIENT ABLE TO ATTEND SESSIONS INDEPENDENTLY?

Yes No

IF NO, WAS THE COMPANION REQUIRED FOR SUPPORT?

11. DID THE CLIENT USE AN ASSISTIVE DEVICE?

Yes No

IF YES, PROVIDE COMMENTS:

12. METHOD OF TRANSPORTATION USED TO ARRIVE TO SESSION

13. WAS THE CLIENT APPROPRIATELY DRESSED AND GROOMED?

Yes No

IF NO, PROVIDE COMMENTS:

14. WERE BEHAVIOURS SOCIALLY APPROPRIATE?

Yes No

IF NO, PROVIDE COMMENTS:

15. WAS THERE AN OBSERVED LOSS OF TRAIN OF THOUGHT OR LAPSE(S) IN ATTENTION?

Yes No

IF YES, PROVIDE COMMENTS:

16. DID THE CLIENT UNDERSTAND AND RESPOND APPROPRIATELY TO INSTRUCTIONS?

Yes No

IF NO, PROVIDE COMMENTS:

17. WAS THERE EVIDENCE IN SPEECH DIFFICULTIES?

Yes No

IF YES, PROVIDE COMMENTS:

18. SUMMARY OF CLIENT PRESENTATION:

Suicide Risk

19. IDENTIFY CLIENT'S LEVEL OF SUICIDE RISK

Low Medium High N/A

PROVIDE SAFETY PLAN AND COMMENTS, AS RELEVANT:

Psychological Assessment Methods Used

LIST AND PROVIDE FINDINGS FROM PSYCHOLOGICAL MEASURES USED (e.g. BDI, BAI, HADS, PCS), AS RELEVANT:

Medications

IDENTIFY CURRENT MEDICATION REGIME, AS RELEVANT:

Treatment Goals and Plans

IDENTIFY CLIENT-CENTRED TREATMENT GOALS

TREATMENT GOAL 1

TREATMENT GOAL 2

TREATMENT GOAL 3

TREATMENT GOAL 4

TREATMENT GOAL 5

TREATMENT PLAN

20. TREATMENT TARGET (RETURN TO WORK FACTOR TO BE ADDRESSED)

21. BARRIERS TO RECOVERY

22. RECOMMENDED INTERVENTION(S) (TREATMENT, MODALITY, STRATEGIES AND ANTICIPATED TREATMENT LENGTH)

23. ARE THERE OTHER COMMENTS THAT MAY IMPACT THE CLIENT'S ABILITY TO RETURN TO PRE-ACCIDENT FUNCTIONING?

Yes No

IF YES, PROVIDE COMMENTS:

Communication Request

24. DO YOU WISH TO HAVE A PHONE CONSULT WITH THE CLAIM FILE HANDLER?

Yes No

25. DO YOU WISH TO HAVE A PHONE CONSULT WITH OTHER CLINICIANS INVOLVED IN THIS CLIENT'S CARE?

Yes No

IF YES, SPECIFY WHICH ONES:

By checking this box, I certify that the information provided is true and correct to the best of my knowledge.

Select one of the following:

- I have obtained consent from the client to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.
- This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.