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Counselling Reassessment Report

If applicable, please select the Lock button before submitting the form.
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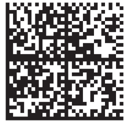

INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

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)

Status of Occupation

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

Comments

PROVIDE ADDITIONAL COMMENTS ON STATUS OF OCCUPATION, AS RELEVANT:

Chief Complaints

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

COMMENT ON ANY CHANGES TO INTENSITY AND/OR SEVERITY OF SYMPTOMS:

Functional Status at the Time of the Accident

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

1. UNDERSTANDING AND COMMUNICATION (cognition)

○ Yes ○ No

IF YES,PROVIDE COMMENTS:

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

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

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

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

4. SOCIAL INTERACTION

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

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

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

6. COMMUNITY INTEGRATION

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

7. COMMENT ON ANY SIGNIFICANT CHANGES TO FUNCTIONAL STATUS SINCE LAST ASSESSMENT:

Current Observed Findings

Comment on client's presentation (as relevant)

8. IS CLIENT ABLE TO ATTEND SESSIONS INDEPENDENTLY?

○ Yes ○ No

IF NO, WAS A COMPANION REQUIRED FOR SUPPORT?

9. DID THE CLIENT USE AN ASSISTIVE DEVICE?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

10. METHOD OF TRANSPORTATION USED TO ARRIVE TO SESSION:

11. WAS THE CLIENT APPROPRIATELY DRESSED AND GROOMED?

○ Yes ○ No

IF NO, PROVIDE COMMENTS:

12. WERE BEHAVIOURS SOCIALLY APPROPRIATE?

○ Yes ○ No

IF NO, PROVIDE COMMENTS:

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

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

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

○ Yes ○ No

IF NO, PROVIDE COMMENTS:

15. WAS THERE EVIDENCE IN SPEECH DIFFICULTIES?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

16. SUMMARY OF CLIENT PRESENTATION:

Suicide Risk

17. 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

UPDATED TREATMENT PLAN

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

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

20. 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

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

○ Yes ○ No

22. 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 investigate, manage or settle a claim. Questions about the collection of this information may be directed to the adjuster, or call 604-661-2800 or contact the Privacy & Freedom of Information (FOI) Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.