Partners in Canadian Veterans Rehabilitation Services™
Partenaires des services de réadaptation aux vétérans canadiens™

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Psychological Consult

Date:
Re: **RSVP ID:**
To:

Veterans Affairs Canada (VAC) has contracted Partners in Canadian Veterans Rehabilitation Services (PCVRS) to provide medical, psycho-social, and vocational rehabilitation services for individuals participating in VAC's Rehabilitation Services and Vocational Assistance Program. These services are designed to assist your patient/client in addressing their individual rehabilitation needs when transitioning to life after service, arising from their eligible health problems.

Services/assistance available may include:

- Medical, psycho-social and/or vocational rehabilitation assessments
- Development and implementation of a rehabilitation plan to address barriers to re-establishment
- Coordination and provision of medical, psycho-social and/or vocational rehabilitation services and interventions

Request:

We are seeking information regarding the following eligible mental health problem(s):

Please also provide information for any other mental health problem(s) that could impact your patient/clients' capacity to participate in rehabilitation services.

To provide the information, please complete the attached form. We would like to confirm the diagnosis(es); establish a prognosis for further functional improvement/gains; and identify any other issues which may be impacting your patient/client's rehabilitation and recovery.

Additional Information/Questions:

- Can you please clarify if treatment that the participant is receiving from you is in the maintenance phase, or rehabilitation phase. If the participant is in the rehabilitation phase of treatment could you indicate the goals frequency and length of time needed to meet the indicated goals.

To respond to these additional questions, please reply in the specific box at the end of the form.

PLEASE SEND PSYCHOLOGICAL CONSULT AND INVOICE TO

Via Fax:
1-877-947-0182

Via Mail:
Partners in Canadian Veterans Rehabilitation Services (PCVRS)
5th Floor, 915 Fort Street Victoria, BC V8V 3K3

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Please note:

- *Invoice must reference Psychological Consult in the description.*
- *Invoices cannot be paid until PCVRS has received the signed and completed Psychological Consult.*
- *Invoice Information: Please ensure your patient/client's name or RSVPID is on the invoice.*

To set up payment via electronic funds transfer (EFT) please provide a void cheque and your preferred email address. This can be submitted alongside your invoice by mail or fax.

Your timely assistance in completing this consultation will help ensure necessary services are provided without delay. If you have any questions, please feel free to call 902-401-4416.

Sincerely,

Sienna Gothreau
Rehabilitation Service Specialist (RSS)
Partners in Canadian Veterans Rehabilitation Services (PCVRS)

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PART 1: Patient/Client Identification	
Name of Patient/Client	**Date of Birth**

PART 2: CONDITION & HISTORY

Eligible Health Problem(s)

**Social Workers: Please do not complete diagnosis below.*

Diagnosis	**Date of first visit pertaining to this condition or date of symptom onset**	**Severity** (mild, moderate or severe)

What is the prognosis related to their eligible mental health problem(s)?
(expected improvement / deterioration / unchanging; expected timeframes)

Frequency of visits Weekly ____ Monthly ____ Other _____

Date of Last Assessment _____
Month/ Day/ Year

Date of next follow-up appointment: _____
Month/ Day/ Year

Please describe your patient/client's current symptoms including frequency, severity and functional impact.

Please outline all clinical findings supporting the diagnosis(es) including observations, test results and consultations. Please attach a copy of any test results and/or consultation reports.

**Social Workers: Please do not comment on diagnosis(es) but can provide any test results or consultations you have on file.*

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What is the current treatment plan?

What are the treatment goals?

Please provide a summary of your patient/client's response to treatment.
☐ **Complete** ☐ **Partial** ☐ **None** ☐ **Too soon to tell (e.g. medication is not at a therapeutic dose, etc.)**

Comments:

Is the recommended treatment program being followed?
☐ **Yes** ☐ **No** **If no, please comment:**

Current Psychotropic Medications

Medication	Prescribing Physician	Date Started	Date of Most Recent Dosage Change	Prescribed to Address Which Symptom(s)	Response

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Describe any other plans for further treatment (pending investigations, specialists, medication changes, etc.)

Are there any known barriers that are limiting or precluding the management of their condition(s)?
(perceived psychosocial barriers, non-eligible health conditions, etc)
☐ **Yes** ☐ **No** **If yes, please provide further details**

At times, there is a need to obtain further functional information. If this is required, are there are any psychological restrictions that may limit participation in a cognitive functional capacity evaluation?
☐ **Yes** ☐ **No** **If yes, please provide further details**

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Cognitive Abilities (Please check)				
Perception	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Memory	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Concentration	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Energy	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Ability to Multi-Task	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Decision Making	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Social Interaction	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Affect/Mood	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Speech	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Insight/Judgement	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact
Self-Criticism	☐ No Impact	☐ Mild Impact	☐ Moderate Impact	☐ Severe Impact

Are there any known restrictions to participation in vocational rehabilitation activities including vocational assessments, participation in training (if required), or other vocational rehabilitation activities?

☐ **Yes** ☐ **No** **If no, please provide further details**

Do you anticipate any permanent functional limitations?

(personal care, daily activities, community/family engagement, leisure, and/or vocational domains)

☐ **Yes** ☐ **No** **If yes, please provide further details**

In your opinion, is your patient/client at risk of harm to self or others?

☐ **Yes** ☐ **No** **If yes, please provide further details**

Are there any complicating factors impacting your patient/client's recovery?

☐ **Yes** ☐ **No** **If yes, please provide further details**

Please identify if any additional supports/services could be helpful to supporting your patient/client's recovery.

☐ **No further supports required**

☐ **Recommend the following additional supports:**

Would you like the Rehabilitation Service Specialist to contact you to discuss assessment and/or rehabilitation planning further?

☐ Yes Phone Number:

Best day/time to contact:

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☐ Not required at this time

Please provide any additional information that you feel the Rehabilitation Service Specialist should be aware of.

PART 3: PAYMENT & CONTACT INFORMATION

PSYCHOLOGIST'S NAME	SPECIALITY	PHONE NUMBER	ADDRESS (Street, City, Province)	Postal Code
I VERIFY THAT ALL PARTS OF THIS FORM HAVE BEEN REVIEWED AND COMPLETED TO THE BEST OF MY KNOWLEDGE				
Date Completed:	**Psychologist's Signature:**		**Stamp:**	

THANK YOU!