Washington State Department of Labor & Industries

Behavioral Health Assessment

State Fund Claim
PO Box 44291
Olympia WA 98504-4291
Fax to Claim file: 360-902-4567

Billing Code available here

This form must be sent upon completion to the Department of Labor & Industries AND the Attending Provider

Section 1: Demographics

Worker's Name		Claim Number
Provider Name	Date of Injury	Date of visit
Face to face time		
Location/Setting		
Attending Provider		

Section 2: Intake and History

Reason for Attending Provider Referral:

Initial Psychometric Measures:

PHQ-4 _____

GCPS Scores Item #1 _____ Item #2 _____

Outside of the treatment sessions with the worker, indicate which providers/L&I resources you will coordinate with to progress treatment goals:

- ☐ Claim Manager
- ☐ Activity Coach
- ☐ Attending Provider
- ☐ Physical Rehabilitation Provider
- ☐ Vocational Rehabilitation Provider
- ☐ Other: _____

What are the behaviors, beliefs, or issues impeding recovery? Describe all that apply.

(e.g., interpersonal relationships, support systems, social isolation, unclear return to work expectations/plans, unclear claims process, catastrophizing, fear avoidance, perceived injustice, recovery expectations, substance abuse)

Worker's Name	Claim Number

Section 3: Goals

Describe mutually agreed upon treatment goals and behavioral interventions/modalities	**Estimated date of completion**
Treatment goal and behavioral interventions/modalities	
Treatment goal and behavioral interventions/modalities	
Treatment goal and behavioral interventions/modalities	
Treatment goal and behavioral interventions/modalities	
Treatment goal and behavioral interventions/modalities	

Note to claim manager (e.g., missed appointments, discharged successfully, etc.):

Therapist's Name	Therapist's Phone Number
Therapist's Signature	Date Signed

Date sent to the Attending Provider: _____