Canadian Society of Medical Examiners
Report Writing Guidelines for Psychiatric Impairments

Preamble

These guidelines address issues that are typically important to the provision of a thorough/comprehensive report of an independent medical evaluation (IME) in any realm of practice.

IME's occur in a variety of circumstances and may have many purposes. Individual cases differ also with respect to the nature and/or degree of injury, impairment and disability. It is therefore clear that the contents of a given report will necessarily reflect the relative importance of many specific factors, and processes, as these relate to the individual's injuries and functions, and to the focus of concern and questions of requesting parties.

These guidelines recognize that professional reports of independent evaluators will appropriately reflect clinicians' needs to integrate their understanding of the most relevant factors as these apply to specific cases, and issues, in a manner that can reasonably be understood by the reader. They are not a one-size-fits-all formula for report writing, nor do they represent specific/minimal standards of practice. They are meant to assist independent evaluators in their efforts to clearly present the matters that are most relevant to understanding the objective medical effects of an injury or illness on an individual's abilities to function in various realms.

Guidelines

Examiner Identification
- Qualifications

Consent
- Nature and purpose of examination
- Release of information
- No traditional doctor – patient relationship
- Confirmation of understanding-signed consent

Relevant Personal & Past Biopsychosocial History
- Patient ID
- Place of birth, where they grew up
- Birth abnormalities, developmental milestones
- Family of origin-early childhood and current relationships
- School history
- Occupational history-reasons for changing jobs, length of employment, current job description, performance review, relationships with managers and peers, current financial/income situation (pre and post disability)
- Marital/relationship/sexual history
- Dependants and their health/special needs
- Avocational history- Interests and recreational activities-pre and post mva
- Legal history

Past Medical History

- ❑ Significant illnesses/injuries/compensable-WSIB-MVA
  - Disability duration
  - Residual symptoms
  - Treatments/investigations
- ❑ Surgical procedures
- ❑ Medications
- ❑ Substance Use
- ❑ Family Psych history
- ❑ Prior Psych history
- ❑ Hospitalizations

History of Motor Vehicle Trauma

- ❑ Subject MVA-description including occupants; where seated; high/low speed
- ❑ Demeanour while relating history
- ❑ Impacts, secondary impacts, $ value of damage
- ❑ Seatbelt, air bag
- ❑ Interior bodily impacts- Head Injury/LOC
- ❑ Individual's ability to exit the vehicle independently-immediate actions
- ❑ Immediate symptoms-psychological & physical
- ❑ Ambulance attendance and transfer details

History of Illness (for assessment of non-MVA claims)

- ❑ Onset of symptoms
- ❑ Primary care provided
- ❑ Diagnostic work-up

Course of Treatment

- ❑ Hospital care; x-rays, diagnosis and treatment (include timeline of treatment)
- ❑ Symptom development and evolution-physical and psychological (include pertinent negatives)
- ❑ Physician follow up
- ❑ Medical referrals (who referred to who)
- ❑ Psychiatric/psychological/psychotherapy referrals
- ❑ Diagnostic studies
- ❑ Bio/Psycho/Social Treatment-includes psychotherapy, pharmacotherapy
- ❑ Surgical treatments
- ❑ Physical treatments
- ❑ Perceived responses to all treatments

Current Symptoms

- ❑ Symptoms in order of severity
- ❑ Prior history of similar symptoms
- ❑ Symptom characteristics
- ❑ Elaboration of all the psych symptoms that developed

Occupational Status and Activities of Daily Living

- Job availability: regular, modified or graduated
- Return to work attempts
- Ability to complete self-care
- Ability to complete housekeeping, home maintenance, care giving
- Ability to complete recreational and other activities of daily living.
- Other restrictions

Psychometrics

- Employed according to the experience, training and knowledge of the examiner (includes items which can objectively help to assess response bias such as: MMPI-II, PAI, SIRS, TOMM)

Clinical Findings/Mental Status Examination

- General Appearance
- General Description as to events that characterised the interview including length of assessment
- Outward evidence of pain/shifting
- Behaviour
- Affect/Mood
- Thought-form and content/suicidal/homicidal/psychosis
- Perception
- Cognition-registration, short-term memory, recent memory, remote memory, attention
- +/- MMSE as required

Review of Documents

- List of documents provided and referred to
- Critical review of relevant documentation

Summary of Clinical Findings and Conclusions

- Critical evaluation leading to diagnostic impression (consideration of cultural factors where appropriate)
- Statement as to response bias issues and their influence on the conclusion (including psychometric results as appropriate)
- Bio/psycho/social causality and incident causality where relevant
- Recommendations for additional testing, evaluation, investigations
- Recommendations for further documentation to be obtained

Response to Questions

- questions dictated
- questions answered concisely and clearly

Last Updated May 2004