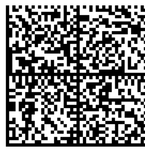
WORK SAFE BC
WORKING TO MAKE A DIFFERENCE



RESIDENTIAL CARE SERVICES CLINICAL CARE PLAN

Initial care plan ❒ Revised care plan ❒

Date *(yyyy-mm-dd)*

HEALTH CARE SERVICES	**FAX**	**MAIL**
Phone 604 232-7787	**604 276-3195**	WorkSafeBC
Toll-free 1 866 244-6404	Toll-free **1 888 922-3299**	PO Box 4700 Stn Terminal
		Vancouver BC V6B 1J1

Worker information

Worker last name	First name	Middle initial	WorkSafeBC claim number
Address line 1		Address line 2	
City	Province/State	Country *(if not Canada)*	Postal code/Zip
Phone number *(please include area code)*	Extension	Birth date *(yyyy-mm-dd)*	

Goals

Care plan

1. **Bathing**	Independent ❒	Dependent ❒	Requires assistance ❒
Client able to			
Requires			
2. **Shaving/oral care**	Independent ❒	Dependent ❒	Requires assistance ❒
Client able to			
Requires			
3. **Hair/skin**	Independent ❒	Dependent ❒	Requires assistance ❒
Client able to			
Requires			
4. **Dressing**	Independent ❒	Dependent ❒	Requires assistance ❒
Client able to			
Requires			

Additional information can be recorded on page 3.

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Residential Care Services Clinical Care Plan *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number

Care plan *(continued)*

5. **Toileting**
   a) Bladder — Client able to
      Requires
      Cleaning of equipment/supplies done by
   b) Bowel — Client able to
      Requires
      Cleaning of equipment/supplies done by

6. **Eating/meal preparation**
   Independent ☐ Dependent ☐ Requires assistance ☐
   Client able to
   Requires

7. **Transfers/mobility/positioning**
   Independent ☐ Dependent ☐ Requires assistance ☐
   Client able to
   Requires

8. **Exercise/ROM/stretching** *(please describe)*

9. **Appointments/activities**

10. **Special tasks**
    Tracheotomy ☐ Medications ☐ Tube feed ☐ Mechanical ventilation ☐ Colostomy ☐ Dressings/ treatments ☐

11. **Special instructions in the event of an emergency** *(please provide detailed instructions)*

Additional information can be recorded on page 3.

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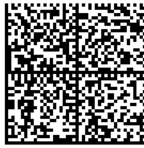

Residential Care Services Clinical Care Plan *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number

Contact information

Name of worker's next of kin	Phone number *(please include area code)*
Emergency contact	Phone number *(please include area code)*
Family doctor	Phone number *(please include area code)*
WorkSafeBC officer	Phone number *(please include area code)*
Provider	Phone number *(please include area code)*

Care plan completed by

Name *(please print)*	Signature
Contact phone number *(please include area code)*	Copy in home ❐ Copy to WorkSafeBC ❐ Copy to agency ❐

Additional information

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.