WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

COMMUNITY OCCUPATIONAL THERAPY REPORT AND PLAN

Please complete this form in full and fax to WorkSafeBC at **604 276-3195** or toll-free at **1 888 922-3299**.

If you have questions, please call Health Care Services at 604 232-7787 or toll-free at 1 888 967-5377, ext. 7787.

Worker information

Worker's last name	First name	Middle initial	WorkSafeBC claim number

Date of initial referral *yyyy-mm-dd*	Date of this assessment *yyyy-mm-dd*
Claim accepted for	Claim not accepted for

Report details

Type of report	Date of discharge *(if applicable)* *yyyy-mm-dd*	Date of this report *yyyy-mm-dd*
Initial Ax ❒ Progress ❒ Discharge ❒		

Occupational therapy services

Please indicate type of occupational therapy service	Comments
Assistive technology (up to three visits) ❒ Treatment (up to six weeks) ❒ Maintenance (up to 12 months) ❒ Other (please explain) ❒ Occupational therapy is not recommended at this time ❒	

Current status

Subjective reports
Objective findings *(e.g. ROM, orthopaedic, neurological, additional information)*

Date: RECEIVED DATE

WORKERS' COMPENSATION BOARD OF B.C.

RESET

Worker's last name	First name	Middle initial	WorkSafeBC claim number

Current status (continued)

Activities of daily living — functional limitations *(please check all that apply)*

Locomotion/movement

Bed mobility ❒ Walking ❒ Transfers ❒ Stair climbing ❒ Other ❒

Comments: _____

Self-care

Bathing ❒ Dressing ❒ Eating ❒ Toileting ❒ Other ❒

Comments: _____

Home management

Household chores ❒ Shopping ❒ Cooking ❒ Laundry ❒ Other ❒

Comments: _____

Productivity: _____

Other:

Analysis

Occupational therapy (OT) plan

Start date *yyyy-mm-dd*	End date *yyyy-mm-dd*	Number of OT visits required
Is this an extension to an existing plan? Yes ❒ No ❒	If yes, please provide the date of approval and name of approving Board officer *yyyy-mm-dd*	

Plan and goals (functional improvement and outcomes expected)

For treatment plans, specify recommended OT and/or support personnel/worker involvement (including length and frequency of visits required).
For maintenance plans, specify OT and/or recommended home care service involvement (including length and frequency of visits required).

Provider information

Provider/business name	Provider phone number ( )
Name of Occupational Therapist	Provider fax number ( )

I declare that the above information is true and correct to the best of my knowledge.

Signature	Date *yyyy-mm-dd*

Date: RECEIVED DATE