WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

VEHICLE MODIFICATION ASSESSMENT

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.

Client's name *Last name* *First name* *Middle initial*		WorkSafeBC (WCB) claim number
Mailing address		City/town
Province	Postal code	Telephone number ( )
Date of injury *yyyy-mm-dd*	Date of birth *yyyy-mm-dd*	
Contact's name *Last name* *First name* *Middle initial*		Telephone number ( )
Date of assessment *yyyy-mm-dd*	Assessment conducted by	Assessment conducted at

Nature of disability

Paraplegic ❒	Level _____	Complete ❒	Incomplete ❒	
Quadriplegic ❒	Level _____	Complete ❒		
Hemiplegic ❒	Left ❒	Right ❒		
Amputee *(please describe)* ❒	_____			
Brain injury *(please describe)* ❒	_____			
Other *(please describe)* ❒	_____			

Comments

Current transportation

Client owns a vehicle Yes ❒ No ❒	Make	Model	Year
Client drives adapted vehicle Yes ❒ No ❒	Make	Model	Year

Client uses public accessible transportation service
Yes ❒ No ❒

Type of adaptations on the current vehicle *(please check all equipment used)*

Hand controls ❒	Steering device ❒	Left foot gas ❒	Power/remote doors ❒
Steering modifications ❒	Six-way seat base ❒	Remote starter ❒	Brake modification ❒
Raised roof ❒	Raised door ❒	Tie downs ❒	Lowered floor ❒
Parking brake ❒	Power ramp ❒	Manual ramp	

Wireless controls for lift/ramp/doors ❒ Wheelchair lift ❒ Type _____ Age _____

Electronic assistive driving devices ❒ Type _____

Other specialized adaptive equipment

Comments

Date: RECEIVED DATE

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WorkSafeBC claim number

Functional use of modified vehicle (How will the client use the vehicle?)

Who will be the principle driver(s)? *(please specify)*

Is the vehicle modified for transportation only (non-driver)?
Yes ❒ No ❒

Is the client a driver or potential driver?
Yes ❒ No ❒

If yes, please specify

Has the client had an adapted driving assessment? If yes, please attach a copy of assessment.
Yes ❒ No ❒ N/A ❒

Does the client have a valid driver's license with appropriate restrictions for required adaptive equipment? *(re-licensing is required for adaptive equipment)*
Yes ❒ No ❒ N/A ❒

If yes, what restrictions apply?

Which location(s) to be modified to accommodate a wheelchair?
Driver ❒ Front passenger ❒ Main compartments ❒ Rear ❒

Comments

Other considerations

Where will the car be parked?

	At Home	*At Work*
Outside	❒	❒
In garage	❒	❒
Carport	❒	❒
Parkade	❒	❒

What is the height clearance of garage/parkade door?

At Home *At Work*

What is the area available on the passenger side and rear of the vehicle for the client to load/unload wheelchair?

Passenger side Home _____ Work _____

Rear Home _____ Work _____

What type of road does the client **normally** travel? *(ground clearance is important for adapted vehicles)*
Paved ❒ Gravel ❒ Combination ❒

Comments

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Vehicle recommendations

Vehicle make	Model	Year
Package number		

Vehicle specifications/options: requirements *(please check required items)*

Automatic transmission	❒	
Power steering	❒	
Power brakes	❒	
Front A/C	❒	Rationale
Cruise control	❒	Rationale
Tilt steering wheel	❒	Rationale
Power door locks	❒	Rationale
Power windows	❒	Rationale
Power mirrors	❒	Rationale
Other	❒	
Comments		

Vehicle modifications: requirements *(please check required items)*

Wheelchair lift	❒	Specify type and location									
Wheelchair ramp	❒	Specify type									
Lowered floor	❒	Specify type									
Raised roof	❒	Specify type									
Raised door(s)	❒	Specify type									
Eyebrow with raised door(s)	❒										
Wheelchair tie down	❒	Specify type and location									
Removable seat	❒	Specify type and location									
Interchangeable seat	❒	Specify									
Electric doors	❒	Side	Double swing	❒	Slide	❒					
		Rear	Double swing	❒	Single swing	❒					
Door and lift switches	❒	Magnetic	❒	Wireless remote	❒	Dashboard	❒	Toggle	❒	Keyed	❒	Pendant	❒
Other	❒										
Comments											

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Vehicle/modification assessment *(please check required items)*

Driver will be driving from	Passenger only ❒	Seat ❒	Wheelchair ❒

Vehicle specifications/options: requirements *(please check required items)*

Hand controls	❒	Specify type
Steering device	❒	Specify type and location
Torso support	❒	Specify
Six-way power seat base	❒	
Parking brake	❒	Specify Manual adapter ❒ or Electric ❒
Steering modifications	❒	Specify
Electronic assistive driving devices	❒	Specify *(list on separate sheet if necessary)*
Electronic controls for secondary functions (i.e. horn, wipers, etc.) *(list on separate sheet if necessary)*	❒	
Console mounted head rest controls for secondary functions *(list on separate sheet if necessary)*	❒	
Electric wheelchair restraint system	❒	
Kneeling system (mini van only)	❒	
Modifications to dashboard functions	❒	
Quad key turner	❒	
Gear shift extension	❒	
Turn signal adapter	❒	
Left foot gas pedal	❒	
Other	❒	
Comments		

Options requested by client *(may not be covered by WorkSafeBC of British Columbia)*

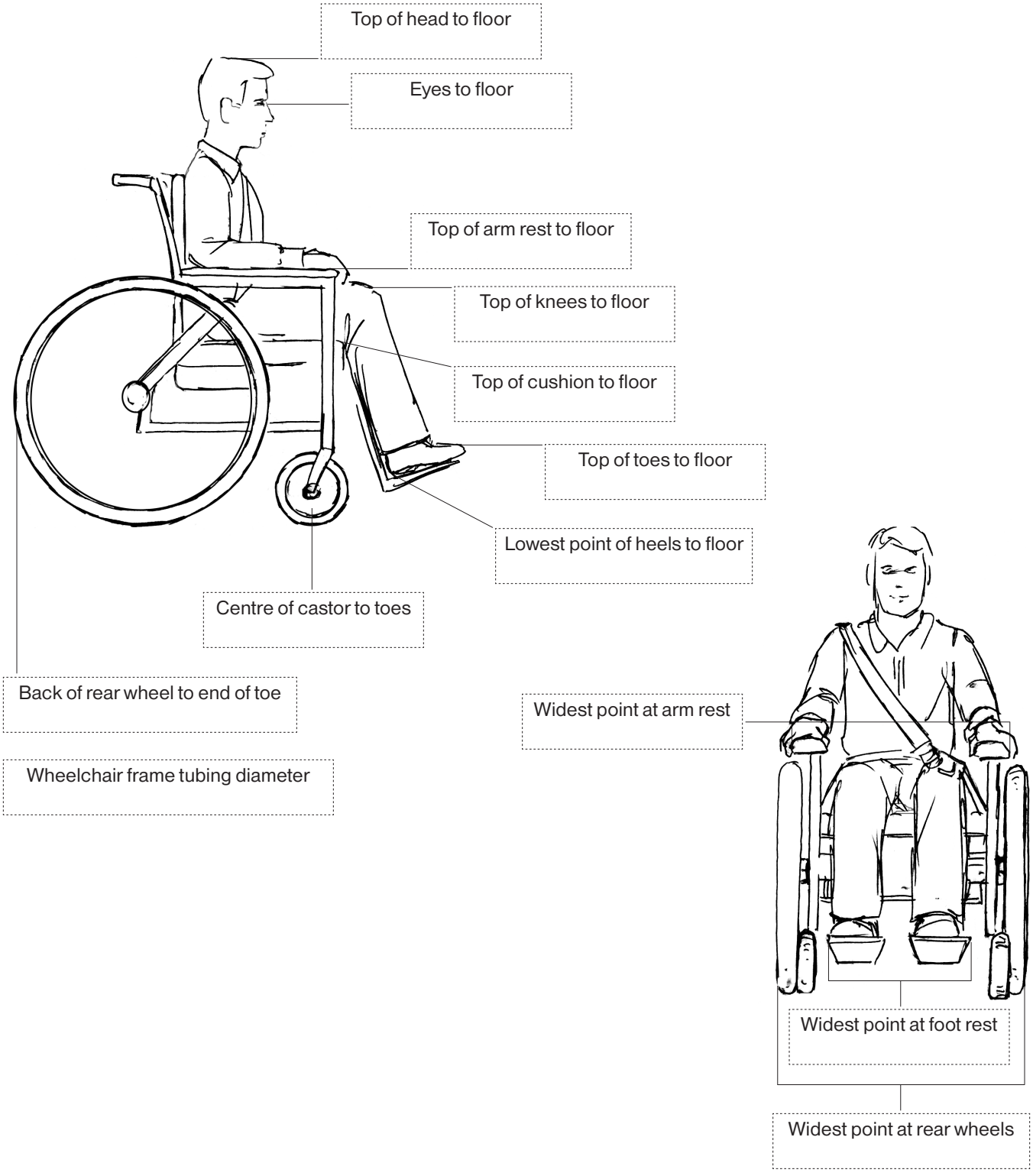
Vehicle	**None** ❒
1.	
2.	
3.	
4.	
Modifications	**None** ❒
1.	
2.	
3.	
4.	
Comments	

Date: RECEIVED DATE

WorkSafeBC wheelchair assessment

Client's name *Last name* *First name* *Middle initial*	Date *yyyy-mm-dd*	WorkSafeBC claim number
Wheelchair make	Model	
Recliner/other	Foot rest *(split/solid)*	

Measurements



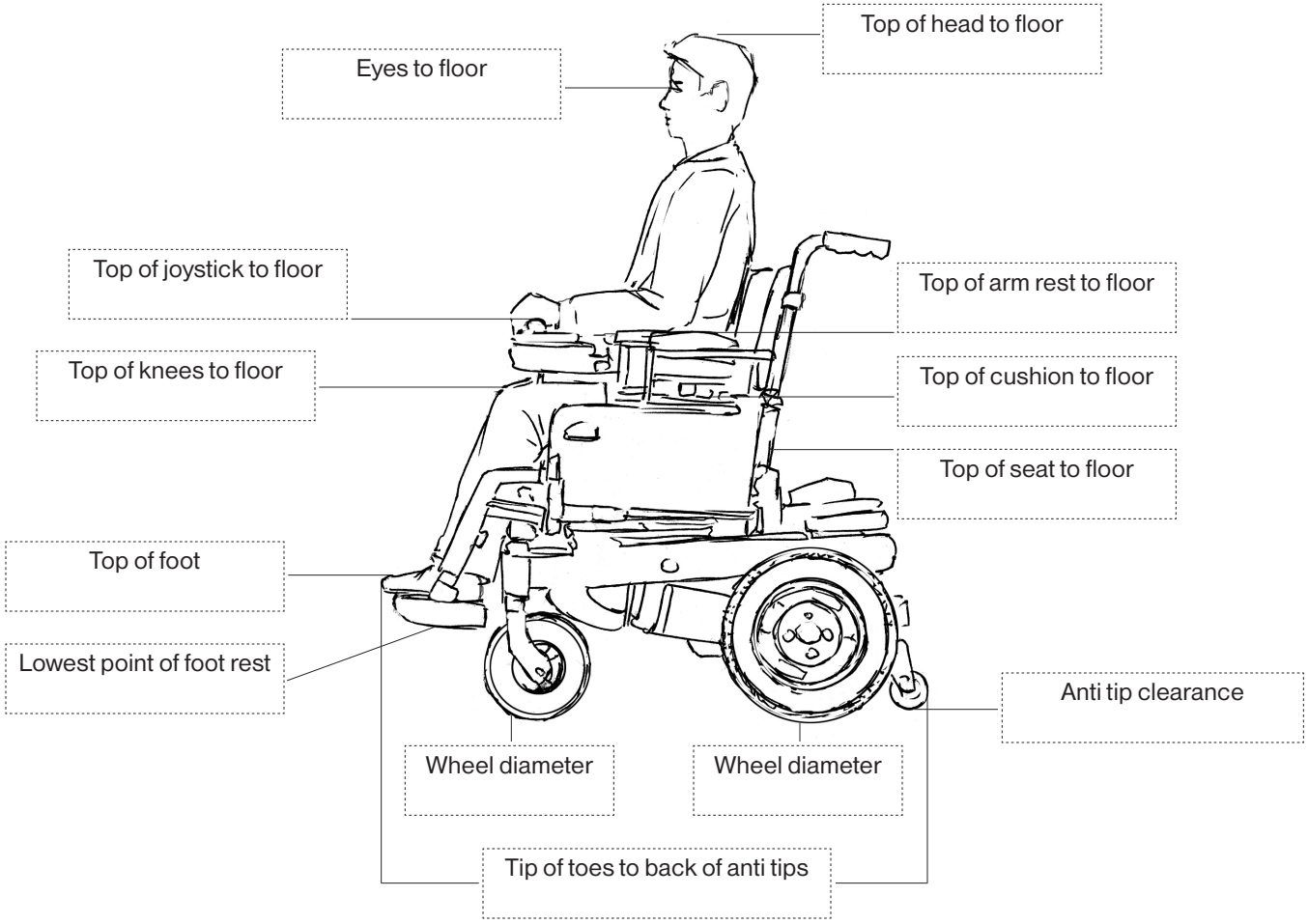
Date: RECEIVED DATE

WorkSafeBC power wheelchair assessment

Client's name (Last name, First name, Middle initial)		Date (yyyy-mm-dd)	WorkSafeBC claim number
Wheelchair make		Model	
Tilt	Recline	Foot rest *(split/solid)*	Year

Measurements

Caution: If wheelchair has tilt/recline, please ensure that wheelchair is in fullest "upright" position when taking measurements.



Width of rear wheels at widest point	Width of front wheels at widest point
Widest point at arm rest	Widest point at foot rest
Turning radius	Length in fully titled position
Length in fully reclined position	Length with legs and back slightly reclined or titled

Wheelchair concerns

Is this the worker's permanent wheelchair and cushion that will be used to access the vehicle? *(please explain)* Yes ❒ No ❒

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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*

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.

Date: RECEIVED DATE