



HOME CARE SERVICES PROGRESS/DISCHARGE REPORT

Please complete and **FAX** this report to WorkSafeBC using the fax number indicated below.

Progress Report Discharge Report

Date of service (for Progress Report it is review date; for Discharge Report it is date of discharge) (yyyy-mm-dd)

CLAIMS CALL CENTRE

Phone 604 231-8888
Toll-free 1 888 967-5377

FAX

604 233-9777
Toll-free **1 888 922-8807**

Worker information

Worker last name	Worker first name	Middle initial	WorkSafeBC claim number
Home address (where service is being provided)			
Home phone number (include area code)			Date of birth (yyyy-mm-dd)

Agency information

Agency/company name	
Mailing address	
Phone number (include area code)	Fax number (include area code)

WorkSafeBC information

WorkSafeBC contact name (please print)	Phone number (include area code)	
Was WorkSafeBC contacted to discuss this report if necessary (i.e., serious issues/concerns, change in service and/or care plan, prior to discharge if discharge report) Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
If yes, name of person contacted	Date contacted (yyyy-mm-dd)	If no, please explain why not

Current services being provided

Description of current informal support (i.e., family/friend(s), church)
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Worker last name	First name	Middle initial	WorkSafeBC claim number
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Description of current services/formal support (*i.e., delivered meals, community nursing, community transport, medical alarm monitoring, education, rehabilitation*)

Description of current services from agency (*please give specific detail*)

Number of hours per day	Frequency of visits per week	Staff type(s)
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Service start date (<i>yyyy-mm-dd</i>)	Last day of service (<i>if applicable</i>) (<i>yyyy-mm-dd</i>)
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Reason for discharge (*if applicable*) N/A

Date of initial nurse assessment (<i>and any subsequent complete nurse assessments, if applicable</i>) (<i>yyyy-mm-dd</i>)	Date of last RN visit (<i>yyyy-mm-dd</i>)
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Current health status (*since last assessment/progress report*)

Summary of claim-related injury and current health status (*please describe in detail*) Improved Declined No change

Current medications (*include name, dosage, and frequency*) Change No change



Worker last name	First name	Middle initial	WorkSafeBC claim number
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Current equipment/adaptive aids (<i>describe any changes</i>)	Change <input type="checkbox"/>	No change <input type="checkbox"/>		
Wound (<i>explain; give details such as size, odour, stage of wound</i>)	Not applicable <input type="checkbox"/>	Improved <input type="checkbox"/>	Declined <input type="checkbox"/>	No change <input type="checkbox"/>
Behaviour/mood (<i>explain</i>)	Improved <input type="checkbox"/>	Declined <input type="checkbox"/>	No change <input type="checkbox"/>	
Cognition (<i>explain</i>)	Improved <input type="checkbox"/>	Declined <input type="checkbox"/>	No change <input type="checkbox"/>	
Psychosocial (<i>explain</i>)	Improved <input type="checkbox"/>	Declined <input type="checkbox"/>	No change <input type="checkbox"/>	
Nutrition/weight (<i>describe current level of nutrition, i.e., any recent change in appetite</i>)				
Safety concerns (<i>explain</i>)	Change <input type="checkbox"/>	No change <input type="checkbox"/>		

Recommendations/plan

Is worker progressing as expected? Yes <input type="checkbox"/> No <input type="checkbox"/>
Recommended changes to current services No change <input type="checkbox"/> Increase services <input type="checkbox"/> Decrease services <input type="checkbox"/> End services <input type="checkbox"/>



Worker last name	First name	Middle initial	WorkSafeBC claim number
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Are there any changes to the care plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, explain in detail
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Service to be provided	Number of hours per day	Number of days per week	Staff type(s)
Service goals (describe goal(s) and expected outcome(s))			

Additional information/comments

I hereby certify that the information contained herein is complete and accurate to the best of my knowledge.

Name	Title	Signature
Next scheduled RN visit (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.