



**CLAIMS CALL CENTRE**  
Phone 604 231-8888  
Toll-free 1 888 967-5377  
M–F, 8:00 a.m. to 4:30 p.m.

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

**MAIL**  
WorkSafeBC  
PO Box 4700 Stn Terminal  
Vancouver BC V6B 1J1

**Worker information**

Worker last name	First name	Middle initial	WorkSafeBC claim number
Date of initial referral (yyyy-mm-dd)	Date of service (assessment date)(yyyy-mm-dd)	Date of this report (yyyy-mm-dd)	
Claim accepted for		Claim not accepted for	

**Occupational therapy services**

Please indicate type of occupational therapy services authorized: Occupational therapy is not recommended at this time <input type="checkbox"/> Assistive technology (up to three visits) <input type="checkbox"/> Treatment <input type="checkbox"/> Maintenance (up to 12 months) <input type="checkbox"/> Other (please explain) <input type="checkbox"/>	Service hours approved (excluding travel): Assistive technology _____ Treatment _____ Maintenance _____ Total hours approved _____
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**Assessment findings**

Subjective reports					
Objective findings (e.g. ROM, orthopaedic, neurological, additional information)					
Activities of daily living — functional limitations (please check all that apply)					
Locomotion/movement					
Bed mobility <input type="checkbox"/>	Walking <input type="checkbox"/>	Transfers <input type="checkbox"/>	Stair climbing <input type="checkbox"/>	Other <input type="checkbox"/>	
Comments					
Self-care					
Bathing <input type="checkbox"/>	Dressing <input type="checkbox"/>	Eating <input type="checkbox"/>	Toileting <input type="checkbox"/>	Other <input type="checkbox"/>	
Comments					
Home management					
Household chores <input type="checkbox"/>	Shopping <input type="checkbox"/>	Cooking <input type="checkbox"/>	Laundry <input type="checkbox"/>	Other <input type="checkbox"/>	
Comments					
Productivity					
Other					
Analysis					





Worker last name	First name	Middle initial	WorkSafeBC claim number
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**Occupational therapy (OT) plan**

<p><b>Plans and goals</b> (functional improvement and outcomes expected) For treatment plans, specify recommended OT and/or support 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).</p>		
Start date (yyyy-mm-dd)	End date (yyyy-mm-dd)	Number of OT visits required
Comments		

**Provider information**

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

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

Signature	Date (yyyy-mm-dd)
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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.