

SPECIAL CARE SERVICES SOCIAL WORKER ASSESSMENT REPORT

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			Date of report (yyyy-mm-dd)		
Worker last name		First name		Middle initial	WorkSafeBC claim number
Mailing address					
City			Province		Postal code
Worker phone (include area code)		Cell phone (include area code)		Date of birth (yyyy-mm-dd)	
Referral source (claim owner/other name, WorkSafeBC office location, etc.)					
Claim accepted for (list injuries/conditions)					
<ul style="list-style-type: none"> • • • • 					
Involved professionals (psychologist, physician, counsellor, etc.)					

Reason for referral

MANDATORY FIELD — REASON FOR REFERRAL (as it relates to the injured worker's claim)

Pending decision on claim
(support accessing community and financial supports prior or during WorkSafeBC decision)

Active claim
(support accessing alternative financial, community, or health supports while benefits are active)

Disallowed claim (transition to community resources)

Conclusion of benefits (transition to community resources)

Decision under appeal
(support accessing transition, community, or other supports while a decision is under appeal)

Serious injury assessment and support

Other NON-COMPENSABLE ISSUES (**REQUIRES CSM APPROVAL PRIOR TO REFERRAL**)

Assessment type

Social Worker Initial Assessment (**SOCWKRINIT**)

Social Worker Progress Report (**SOCWKRPROG**)

Social Worker Closure Report (**SOCWKRCLSR**)



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Assessment details

<p>Presenting issue(s) <i>(identify how the intervention and intervention goals relate to the overall claim)</i></p>
<p>Worker's background/history/current situation <i>(including financial assessment)</i></p>
<p>Home circumstances, informal/formal support <i>(including current family and living situation and support within the home and external to the home)</i></p>
<p>Health/medication management <i>(including any current identified physical health, pain, and disability/mobility strengths or barriers; include any recent changes)</i></p>



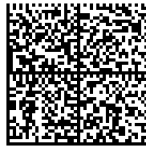
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Emotional/psychological/mental health *(Describe any problems related to loss, bereavement, memory, communication, orientation, sleep, anxiety, phobias, risk behaviour, depression, lowering of energy, drive and interest, self-neglect, severe mental illness, or other emotional or psychological problems. Describe impact on daily living/independence.)*

Social circumstances *(Describe relevant issues, maintaining social contacts/networks, and involvement in activities in their local community. Are they as active as they are able to be or wish to be? What help do they require?)*

Specific WorkSafeBC claims-related interventions/concerns

Protective factors *(strengths, family supports, etc.)*



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Other (including any substance use/misuse concerns, self-care, or hygiene concerns)

Goals/interventions

Issues addressed	Yes	Actions and recommendations	By who/By when
Housing	<input type="checkbox"/>		
Transportation	<input type="checkbox"/>		
Financial management	<input type="checkbox"/>		
Family support	<input type="checkbox"/>		
Alcohol and drug misuse	<input type="checkbox"/>		
Self-harm (including risk of suicide) <i>* If yes, complete and include risk assessment</i>	<input type="checkbox"/>		
Threats of violence to others	<input type="checkbox"/>		
Mental health	<input type="checkbox"/>		
Community support services	<input type="checkbox"/>		
Employment	<input type="checkbox"/>		
Sleep/rest	<input type="checkbox"/>		



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Issues addressed	Yes	Actions and recommendations	By who/By when
Mobility equipment	<input type="checkbox"/>		
Nutrition/meal preparation	<input type="checkbox"/>		
Shopping/housework	<input type="checkbox"/>		
Communication	<input type="checkbox"/>		
Other	<input type="checkbox"/>		

Recommended duration of social work intervention *(including expected outcomes)*

Request for ongoing social work intervention

*(Rationale **REQUIRED** for ongoing service beyond 4–6 sessions. Include expected outcomes.)*



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Summary

Social worker name	Social worker phone (include area code)	Date report submitted (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.