



Initial care plan

Revised care plan

Date (yyyy-mm-dd)

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
Address line 1		Address line 2	
City	Province/State	Country (if not Canada)	Postal code/Zip
Phone number (please include area code)	Extension	Birthdate (yyyy-mm-dd)	

Goals

Care plan

1. Bathing	Independent <input type="checkbox"/>	Dependent <input type="checkbox"/>	Requires assistance <input type="checkbox"/>
Client able to			
Requires			
2. Shaving/oral care	Independent <input type="checkbox"/>	Dependent <input type="checkbox"/>	Requires assistance <input type="checkbox"/>
Client able to			
Requires			
3. Hair/skin	Independent <input type="checkbox"/>	Dependent <input type="checkbox"/>	Requires assistance <input type="checkbox"/>
Client able to			
Requires			
4. Dressing	Independent <input type="checkbox"/>	Dependent <input type="checkbox"/>	Requires assistance <input type="checkbox"/>
Client able to			
Requires			

Additional information can be recorded on page 3.





Worker last name	First name	Middle initial	WorkSafeBC claim number
------------------	------------	----------------	-------------------------

Care plan (continued)

5. Toileting			
a) Bladder – Client able to			
Requires			
Cleaning of equipment/supplies done by			
b) Bowel – Client able to			
Requires			
Cleaning of equipment/supplies done by			
6. Eating/meal preparation			
Independent <input type="checkbox"/>	Dependent <input type="checkbox"/>	Requires assistance <input type="checkbox"/>	
Client able to			
Requires			
7. Transfers/mobility/positioning			
Independent <input type="checkbox"/>	Dependent <input type="checkbox"/>	Requires assistance <input type="checkbox"/>	
Client able to			
Requires			
8. Exercise/ROM/stretching <i>(please describe)</i>			
9. Appointments/activities			
10. Special tasks			
Tracheotomy <input type="checkbox"/>	Medications <input type="checkbox"/>	Tube feed <input type="checkbox"/>	Mechanical <input type="checkbox"/> ventilation
Colostomy <input type="checkbox"/>	Dressings/ treatments <input type="checkbox"/>		
11. Special instructions in the event of an emergency <i>(please provide detailed instructions)</i>			



Worker last name	First name	Middle initial	WorkSafeBC claim number
------------------	------------	----------------	-------------------------

Contact information

Name of worker's next of kin	Phone number <i>(please include area code)</i>
Emergency contact	Phone number <i>(please include area code)</i>
Family doctor	Phone number <i>(please include area code)</i>
WorkSafeBC officer	Phone number <i>(please include area code)</i>
Provider	Phone number <i>(please include area code)</i>

Care plan completed by

Name <i>(please print)</i>	Signature
Contact phone number <i>(please include area code)</i>	Copy in home <input type="checkbox"/> Copy to WorkSafeBC <input type="checkbox"/> Copy to agency <input type="checkbox"/>

Additional information

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.