



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 (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
- Assistive technology (up to three visits)
- Treatment
- Maintenance (up to 12 months)
- Other (please explain)

Current status

Subjective reports
Objective findings (updates re: ROM, orthopaedic, neurological, additional information)
Activities of daily living — functional limitations (status update re: previously identified issues; new issues; interventions)
Other
Analysis

Occupational therapy (OT) plan and goals

Provide update re status of short and long term goals, functional improvement and outcomes expected. Specify recommended OT and/or support personnel involvement or home care involvement (including length and frequency of visits required)

Start date of OT Services plan (yyyy-mm-dd)	Proposed end date of OT Services plan (yyyy-mm-dd)	Total number of OT visits required
Is this an extension to an existing plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, please provide the date of approval and name of approving Board officer (yyyy-mm-dd)





Worker last name	First name	Middle initial	WorkSafeBC claim number
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Comments

Service hours	Initial hours approved	Hours used	Hours remaining	Additional hours authorized
Assistive technology				
Treatment				
Maintenance (up to 12 months)				

Provider information

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

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

Signature	Date <i>(yyyy-mm-dd)</i>
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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.

