



Please complete this form in full and **FAX** to WorkSafeBC at one of the numbers indicated below.

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 last name		First name		Middle initial	WorkSafeBC claim number
Mailing address				City/town	
Province		Postal code		Telephone number <i>(please include area code)</i>	
Date of injury <i>(yyyy-mm-dd)</i>			Date of birth <i>(yyyy-mm-dd)</i>		
Contact's name				Telephone number <i>(please include area code)</i>	
Date of service <i>(Date of assessment yyyy-mm-dd)</i>		Assessment conducted by		Assessment conducted at	

Nature of disability

Paraplegic	<input type="checkbox"/>	Level _____	Complete <input type="checkbox"/>	Incomplete <input type="checkbox"/>
Quadriplegic	<input type="checkbox"/>	Level _____	Complete <input type="checkbox"/>	
Hemiplegic	<input type="checkbox"/>	Left <input type="checkbox"/>	Right <input type="checkbox"/>	
Amputee <i>(please describe)</i>	<input type="checkbox"/>	_____		
Brain injury <i>(please describe)</i>	<input type="checkbox"/>	_____		
Other <i>(please describe)</i>	<input type="checkbox"/>	_____		
Comments				

Current transportation

Client owns a vehicle Yes <input type="checkbox"/> No <input type="checkbox"/>		Make	Model	Year
Client drives adapted vehicle Yes <input type="checkbox"/> No <input type="checkbox"/>		Make	Model	Year
Client uses public accessible transportation service Yes <input type="checkbox"/> No <input type="checkbox"/>				
Type of adaptations on the current vehicle <i>(please check all equipment used)</i>				
Hand controls <input type="checkbox"/>	Steering device <input type="checkbox"/>	Left foot gas <input type="checkbox"/>	Power/remote doors <input type="checkbox"/>	
Steering modifications <input type="checkbox"/>	Six-way seat base <input type="checkbox"/>	Remote starter <input type="checkbox"/>	Brake modification <input type="checkbox"/>	
Raised roof <input type="checkbox"/>	Raised door <input type="checkbox"/>	Tie downs <input type="checkbox"/>	Lowered floor <input type="checkbox"/>	
Parking brake <input type="checkbox"/>	Power ramp <input type="checkbox"/>	Manual ramp <input type="checkbox"/>		
Wireless controls for lift/ramp/doors <input type="checkbox"/>	Wheelchair lift <input type="checkbox"/>	Type _____	Age _____	
Electronic assistive driving devices <input type="checkbox"/>	Type _____			
Other specialized adaptive equipment				
Comments				





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Functional use of modified vehicle *(How will the client use the vehicle?)*

Who will be the principle driver(s)? <i>(please specify)</i>	
Is the vehicle modified for transportation only (non-driver)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the client a driver or potential driver? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please specify
Has the client had an adapted driving assessment? If yes, please attach a copy of assessment. Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Does the client have a valid driver's license with appropriate restrictions for required adaptive equipment? <i>(re-licensing is required for adaptive equipment)</i> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
If yes, what restrictions apply?	
Which location(s) to be modified to accommodate a wheelchair? Driver <input type="checkbox"/> Front passenger <input type="checkbox"/> Main compartments <input type="checkbox"/> Rear <input type="checkbox"/>	
Comments	

Other considerations

Where will the car be parked?	<i>At home</i>	<i>At work</i>	
	Outside <input type="checkbox"/>	Outside <input type="checkbox"/>	
	In garage <input type="checkbox"/>	In garage <input type="checkbox"/>	
	Carport <input type="checkbox"/>	Carport <input type="checkbox"/>	
	Parkade <input type="checkbox"/>	Parkade <input type="checkbox"/>	
What is the height clearance of garage/parkade door?	<i>At home</i>	<i>At work</i>	
What is the area available on the passenger side and rear of the vehicle for the client to load/unload wheelchair?			
Passenger side	Home _____	Work _____	
Rear	Home _____	Work _____	
What type of road does the client normally travel? <i>(ground clearance is important for adapted vehicles)</i>	Paved <input type="checkbox"/>	Gravel <input type="checkbox"/>	Combination <input type="checkbox"/>
Comments			



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Vehicle recommendations

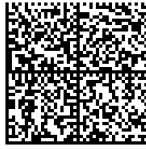
Vehicle make	Model	Year
Package number		

Vehicle specifications/options: requirements *(please check required items)*

Automatic transmission	<input type="checkbox"/>	
Power steering	<input type="checkbox"/>	
Power brakes	<input type="checkbox"/>	
Front A/C	<input type="checkbox"/>	Rationale
Cruise control	<input type="checkbox"/>	Rationale
Tilt steering wheel	<input type="checkbox"/>	Rationale
Power door locks	<input type="checkbox"/>	Rationale
Power windows	<input type="checkbox"/>	Rationale
Power mirrors	<input type="checkbox"/>	Rationale
Other	<input type="checkbox"/>	
Comments		

Vehicle modifications: requirements *(please check required items)*

Wheelchair lift	<input type="checkbox"/>	Specify type and location
Wheelchair ramp	<input type="checkbox"/>	Specify type
Lowered floor	<input type="checkbox"/>	Specify type
Raised roof	<input type="checkbox"/>	Specify type
Raised door(s)	<input type="checkbox"/>	Specify type
Eyebrow with raised door(s)	<input type="checkbox"/>	
Wheelchair tie down	<input type="checkbox"/>	Specify type and location
Removable seat	<input type="checkbox"/>	Specify type and location
Interchangeable seat	<input type="checkbox"/>	Specify
Electric doors	<input type="checkbox"/>	Side Double swing <input type="checkbox"/> Slide <input type="checkbox"/> Rear Double swing <input type="checkbox"/> Single swing <input type="checkbox"/>
Door and lift switches	<input type="checkbox"/>	Magnetic <input type="checkbox"/> Wireless remote <input type="checkbox"/> Dashboard <input type="checkbox"/> Toggle <input type="checkbox"/> Keyed <input type="checkbox"/> Pendant <input type="checkbox"/>
Other	<input type="checkbox"/>	
Comments		



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Vehicle/modification assessment *(please check required items)*

Driver will be driving from	Passenger only <input type="checkbox"/>	Seat <input type="checkbox"/>	Wheelchair <input type="checkbox"/>
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Vehicle specifications/options: requirements *(please check required items)*

Hand controls <input type="checkbox"/>	Specify type
Steering device <input type="checkbox"/>	Specify type and location
Torso support <input type="checkbox"/>	Specify
Six-way power seat base <input type="checkbox"/>	
Parking brake <input type="checkbox"/>	Specify <input type="checkbox"/> Manual adapter <input type="checkbox"/> or <input type="checkbox"/> Electric <input type="checkbox"/>
Steering modifications <input type="checkbox"/>	Specify
Electronic assistive driving devices <input type="checkbox"/>	Specify <i>(list on separate sheet if necessary)</i>
Electronic controls for secondary functions (i.e. horn, wipers, etc.) <input type="checkbox"/> <i>(list on separate sheet if necessary)</i>	Console mounted head rest controls for secondary functions <input type="checkbox"/> <i>(list on separate sheet if necessary)</i>
Electric wheelchair restraint system <input type="checkbox"/>	
Kneeling system (mini van only) <input type="checkbox"/>	
Modifications to dashboard functions <input type="checkbox"/>	
Quad key turner <input type="checkbox"/>	
Gear shift extension <input type="checkbox"/>	
Turn signal adapter <input type="checkbox"/>	
Left foot gas pedal <input type="checkbox"/>	
Other <input type="checkbox"/>	
Comments	

Options requested by client *(may not be covered by WorkSafeBC)*

Vehicle	None <input type="checkbox"/>
1.	
2.	
3.	
4.	
Modifications	None <input type="checkbox"/>
1.	
2.	
3.	
4.	
Comments	

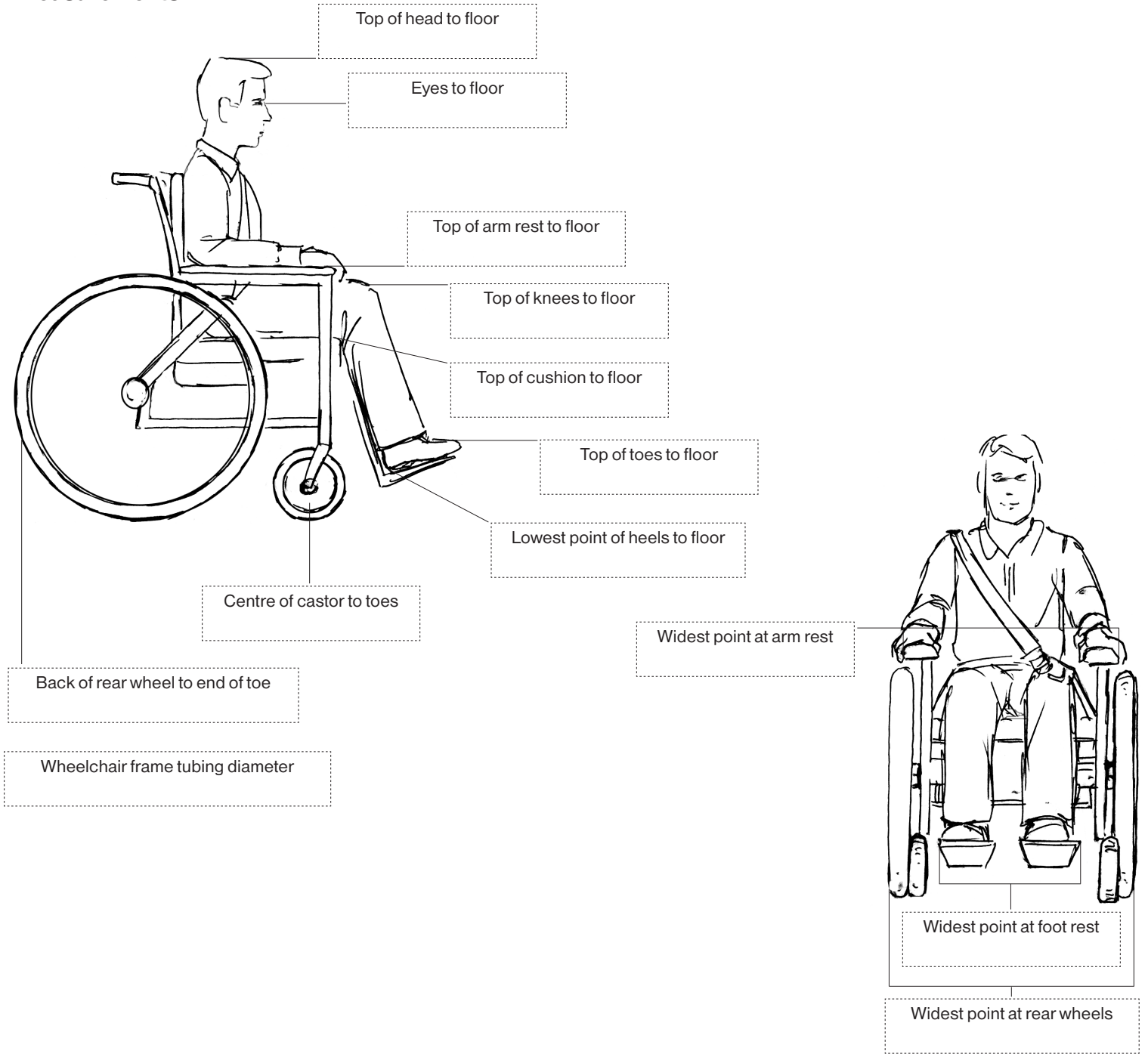


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WorkSafeBC wheelchair assessment

Wheelchair make	Model	
Recliner/other	Foot rest (<i>split/solid</i>)	Date (<i>yyyy-mm-dd</i>)

Measurements





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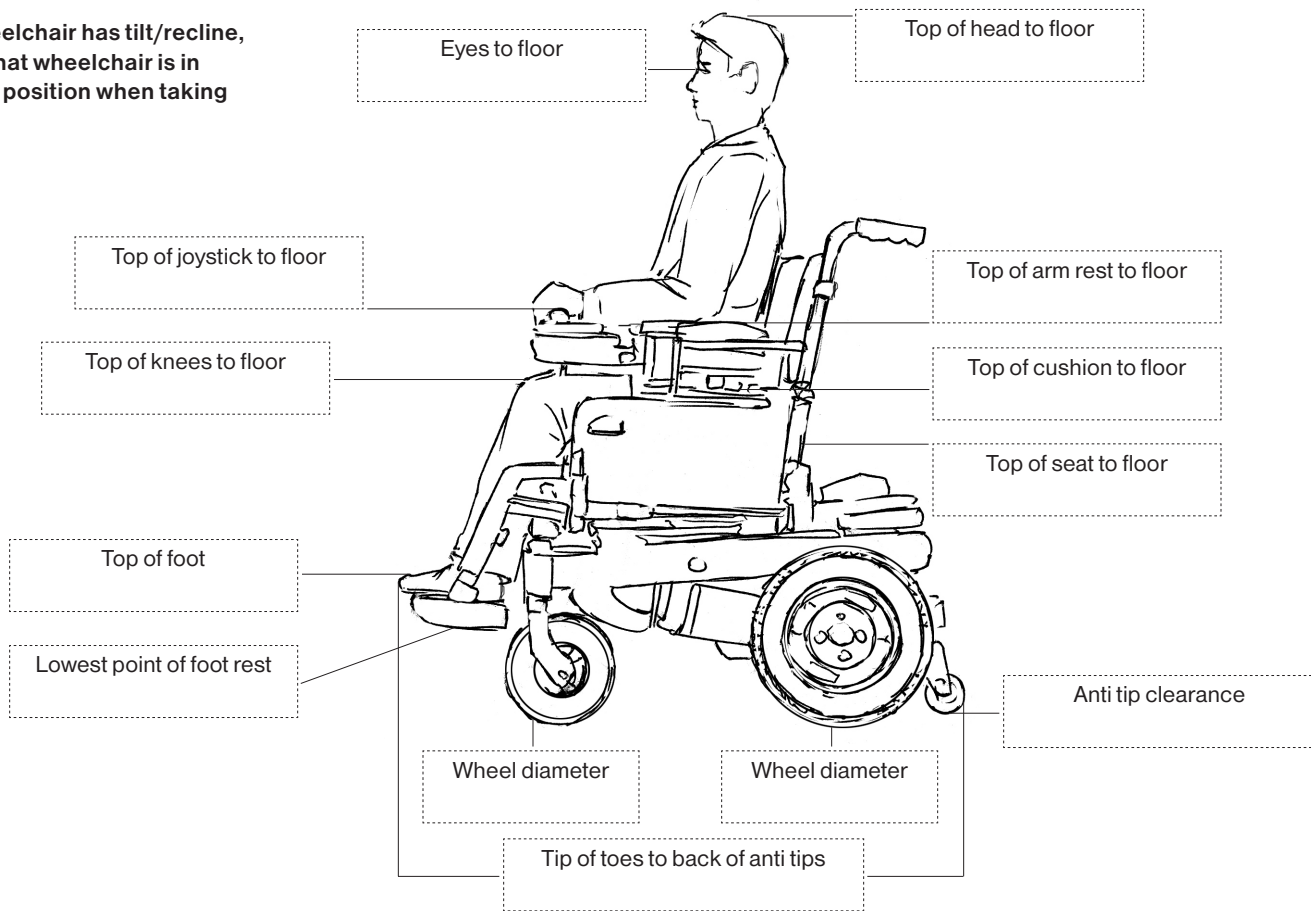
Date (yyyy-mm-dd)

WorkSafeBC power wheelchair assessment

Wheelchair make		Model	
Tilt	Recline	Foot rest (split/solid)	Year

Measurements

Caution: If wheelchair has tilt/recline, please ensure that wheelchair is in fullest "upright" position when taking measurements.



Width of rear wheels at widest point	Width of front wheels at widest point
Widest point at arm rest	Widest point at foot rest
Turning radius	Length in fully tilted position
Length in fully reclined position	Length with legs and back slightly reclined or tilted

Wheelchair concerns

Is this the worker's permanent wheelchair and cushion that will be used to access the vehicle? *(please explain)* Yes No



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Provider information

Provider/business name	Provider phone number <i>(please include area code)</i>
Name of occupational therapist	Provider fax number <i>(please 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.