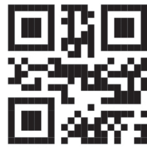
WORK SAFE BC



Community Care Facility
Clinical Care Plan

Date of service (date of assessment) (yyyy-mm-dd)

Worker and claim information

Worker's last name	First name	Middle initial	WorkSafeBC claim number	Date of birth (yyyy-mm-dd)

Name of worker's next of kin	Phone number
Name of attending physician	Phone number
Name(s) of other health professional(s) involved	Phone number(s)
WorkSafeBC officer's name	Phone number

Current supports

Description of current informal support (who is involved and how they assist — e.g., family and/or friend[s], community groups, religious organizations)	
Description of current services and formal support **not** being delivered by the facility (e.g., wound care team, occupational therapy, physiotherapy, medical alarm system monitoring)	
Is there evidence of any factors affecting service that WorkSafeBC should know about? ☐ Yes ☐ No	If yes, provide details

Current health status

Summary of claim-related injury	
Pertinent non–claim-related health history	
Functional status and abilities (including pain scale, mini mental state examination [MMSE], etc.)	
Bowel and bladder care (provide details, including required supplies and equipment)	
Current medications (list all, including name, dosage, and frequency)	N/A ☐
Allergies (food and/or other)	N/A ☐
Nutrition and weight (describe current level of nutrition and appetite and whether worker is independent with feeding or requires assistance; comment on any changes or concerns)	

Integumentary

Skin integrity and wounds (describe in detail for each wound as applicable — e.g., wound history, size, stage, odour, drainage)	N/A ☐

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Worker's last name	First name	Middle initial	WorkSafeBC claim number

Foot care (describe condition of the feet and identify possible factors related to the injury and interventions)	N/A ☐

Behaviour, cognition, and psychosocial

Behaviour and mood

☐ No issues at present ☐ Anxious ☐ Agitated
☐ Co-operative ☐ Angry (expresses this verbally) ☐ Withdrawn

Comments (provide details)

Cognition

☐ Mentally alert ☐ Intermittent confusion ☐ Always confused

Oriented to

☐ Person ☐ Place ☐ Time

Able to

☐ Make decisions ☐ Communicate ☐ Comprehend ☐ Remember appointments
☐ Problem solve ☐ Initiate ☐ Concentrate

Comments (provide details)

Psychosocial

☐ No issues at present ☐ No social relationships ☐ Staff interaction only ☐ Involved in social activities

Goes out

☐ Regularly ☐ Occasionally ☐ Rarely

Comments (provide details)

Current equipment and adaptive aids

General

☐ Manual wheelchair ☐ Straight-legged walker ☐ Scooter ☐ Brace
☐ Power wheelchair ☐ Two-wheeled walker ☐ Stair lift ☐ Splints
☐ Bariatric wheelchair ☐ Four-wheeled walker ☐ Cane ☐ Prosthesis
☐ Other ☐ With seat ☐ Crutches

Comments

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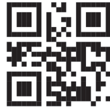

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Worker's last name	First name	Middle initial	WorkSafeBC claim number

Bedroom

Bed

☐ Hospital ☐ Adjustable ☐ Bariatric

Mattress (describe, including toppers, cushions, and/or wound prevention)

☐ Lift (ceiling or portable) ☐ Bed rail(s) ☐ Transfer bench ☐ Call bell

Comments

Bathroom

☐ Ensuite ☐ Shared

Worker requires

☐ Grab bars ☐ Bath board ☐ Commode
☐ Tub bar ☐ Bath chair ☐ Raised toilet seat
☐ Safety grips and/or bath mat ☐ Bath bench ☐ Lift (ceiling or portable)
☐ Hand-held shower

Comments

Safety

Identify and comment on any safety concerns that are or may be present and the strategies required to manage these risks

Recommendations and plan

Description of services to be provided by facility (please provide specific details, such as what tasks are to be performed by each type of personnel [e.g., RN, RPN, LPN, HCA, other])

Per-diem amount

Comments (as needed for clarification of RN, RPN, LPN, HCA, and other personnel hours and per-diem amount)

Service goals (describe specific goal[s] and expected outcome[s] for each type of personnel as applicable)

Service start date (yyyy-mm-dd)	Anticipated discharge date, if known or applicable (yyyy-mm-dd)

Was the WorkSafeBC officer contacted to discuss this report if necessary?
☐ Yes ☐ No

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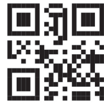

Community Care Facility
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Worker's last name	First name	Middle initial	WorkSafeBC claim number

If yes, name of person contacted	Date contacted (yyyy-mm-dd)	If no, explain why not

Date authorization was received from WorkSafeBC (yyyy-mm-dd)	Name of WorkSafeBC officer who authorized the care plan

Additional information

Comments

Provider's information

Facility or company's name	Payee number

Mailing address

City	Province	Postal code	Phone number	Fax number

Email address (optional)

By signing below, I certify that the information contained in this report is complete and accurate to the best of my knowledge.

Assessment completed by (first and last name)	Title (RN, RPN, or LPN)	Contact phone number	Signature

Payment Services
Phone 604.276.3085
Toll-free 1.888.422.2228

Fax
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Toll-free **1.888.922.8807**

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