Community Care Facility
Progress or Discharge Report

Date of service (date of assessment) (yyyy-mm-dd)
☐ Community Care Facility Progress Report ☐ Community Care Facility Discharge Report

Worker and claim information

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

WorkSafeBC officer's name	Phone number

Current services (provided up to and including the date of this report)

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)		
Description of current services from facility (please give specific details, such as what tasks are being performed and by which type of personnel [e.g., RN, RPN, LPN, HCA, other])		
Service start date (yyyy-mm-dd)	Actual or anticipated discharge date (if applicable) (yyyy-mm-dd)	Date of last nursing assessment (prior to this review) (yyyy-mm-dd)

Current health status (since last assessment/progress report)

Summary of claim-related injury				
Pertinent non–claim-related health update		☐ Improved	☐ Declined	☐ No change
Functional status and abilities update (including pain scale, mini mental state examination [MMSE], etc.)		☐ Improved	☐ Declined	☐ No change
Bowel and bladder care (provide details, including required supplies and equipment)	☐ N/A	☐ Improved	☐ Declined	☐ No change
Skin integrity and wounds (include clinical details such as size, odour, and stage of wound)	☐ N/A	☐ Improved	☐ Declined	☐ No change
Foot care (describe condition of the feet and identify possible factors related to the injury and interventions)	☐ N/A	☐ Improved	☐ Declined	☐ No change
Current medications (list all, including name, dosage, and frequency)			☐ Change	☐ No change
Current equipment and adaptive aids (list all and describe any changes)			☐ Change	☐ No change
Behaviour and mood (explain)		☐ Improved	☐ Declined	☐ No change
Cognition (explain)		☐ Improved	☐ Declined	☐ No change

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Psychosocial (explain)	☐ Improved	☐ Declined	☐ No change
Nutrition and weight (describe current level of nutrition and appetite; comment on any changes or concerns)	☐ Improved	☐ Declined	☐ No change
Safety concerns (explain)		☐ Change	☐ No change

Recommendations and plan

Is the worker progressing as expected? ☐ Yes ☐ No	Recommended changes to current services ☐ No change ☐ Decrease services ☐ Increase services ☐ End services and discharge	
Are there any changes to the care plan? ☐ Yes ☐ No	If yes, confirm you have submitted an updated Clinical Care Plan (Form 83D508) ☐ Yes, I have submitted an updated Clinical Care Plan	
Was the WorkSafeBC officer contacted to discuss this report if necessary? (e.g., serious issues or concerns, change in service and/or care plan) ☐ Yes ☐ No		
If yes, name of person contacted	Date contacted (yyyy-mm-dd)	If no, explain why not
If there are no changes to the care plan, provide the date a WorkSafeBC officer last authorized the current care plan (yyyy-mm-dd)	Name of WorkSafeBC officer who authorized the care plan	
Comments (as needed for clarification of RN, RPN, LPN, HCA, or other personnel's hours)		
Service goals (describe specific goal[s] and expected outcome[s] for each type of personnel as applicable)		

Additional information

Comments

Provider's information

Facility's or company's name			Payee number	
Mailing address				
City	Province	Postal code	Phone number	Fax number
Email address (optional)				

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

Name (first and last)	Title (RN, RPN, or LPN)	Contact phone number	Signature

Payment Services
Phone 604.276.3085
Toll-free 1.888.422.2228

Fax
604.233.9777
Toll-free **1.888.922.8807**

Mail
Payment Services, WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

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