



# Foot Care Services Assessment Report

Assessment report is due within 5 business days of the date of nursing service visit.

Note: The date of service on the invoice must match the date of service on this form for payment to be processed.

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

## Report type (check one only)

<input type="checkbox"/> 83D605 Initial Assessment Report	<input type="checkbox"/> 83D606 Progress Assessment Report	<input type="checkbox"/> 83D607 Discharge Assessment Report
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## Worker's information

Worker's last name	First name	Middle initial	WorkSafeBC claim number
Home address			
City	Province	Postal code	Phone number
Date of birth (yyyy-mm-dd)			
Name of primary care practitioner			Phone number

## WorkSafeBC's information

WorkSafeBC officer's name and title	Phone number
Date the WorkSafeBC officer was contacted to discuss the findings of this assessment and approval was received for services (yyyy-mm-dd)	

## Provider's information

Provider's or company's name	Payee number
Service delivery address (where service was provided, if different than worker's home address)	Provider's phone number

## Current supports

Description of current informal support(s) (who is involved and how they assist — e.g., family and/or friends, community groups, religious organizations)
Description of current formal support(s) (e.g., Home Care Services, Occupational Therapy, Physiotherapy, delivered meals, health authority support, community transport, medical alarm system monitoring, rehabilitation)



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Is there evidence of any factors affecting service that WorkSafeBC should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide details
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## Health status

Summary of claim-related injury relating to the need for Foot Care Services	
<b>Medical history</b> (e.g., amputations, PVD, knee or hip replacements, diabetes [I or II], cardiovascular condition, peripheral neuropathy, pulmonary condition, thyroid conditions, arthritis, smoking, previous foot ulceration)	
<b>Current medications</b> (list all, including name, dosage, and frequency)	N/A <input type="checkbox"/>
<b>Allergies</b> (food, medication, environmental, and/or other)	N/A <input type="checkbox"/>
<b>Nutrition</b> (describe current level of nutrition and appetite; comment on any changes or concerns)	
<b>Mobility</b> (describe gait, mobility/transfer equipment, activity level, assistance needed, history of falls, ability to reach feet, etc.)	



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**Footwear** (describe socks, shoes, orthotics, including whether they are excessively worn and/or too narrow/wide/short resulting in rubbing, erythema, blister, or callus, etc.)

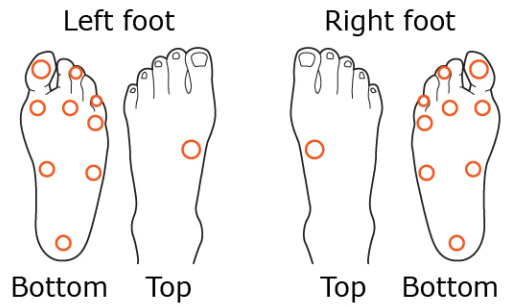
## Foot Care Services assessment

Physical assessment		Left	Right
Nails	Comments (provide details on length, colour, thickness, involution, ingrown, tinea pedis, etc.)		
Circulation (lower leg, foot & toes)	Comments (provide details on colour, warmth, sweating, edema, dependent rubor, pallor, varicosities, etc.)		
	Posterior tibial pulse (comment whether bounding, normal, present but diminished, or absent)		
	Dorsalis pedis pulse (comment whether bounding, normal, present but diminished, or absent)		
	Cap refill: less than 3 seconds?		
Movement (lower leg, foot & toes)	Comments (provide details on dorsiflexion, plantar flexion, toe and heel rotation, pronation, supination, etc.)		
Sensation (lower leg, foot & toes)	Comments (provide details — e.g., pain)		



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### Monofilament test

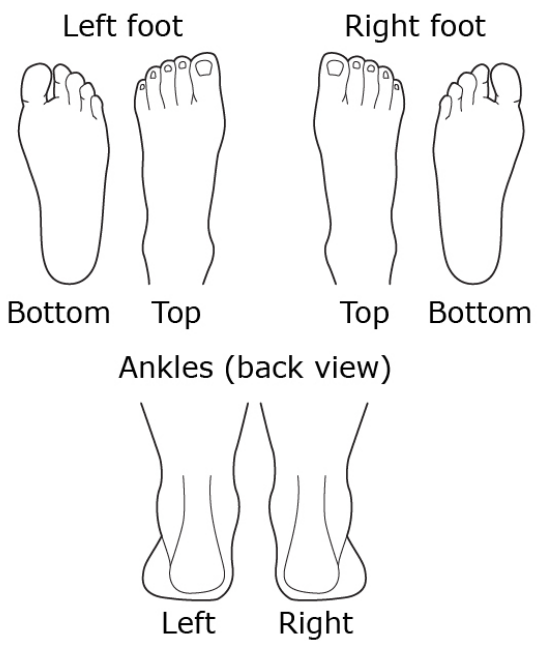


Left foot score:            /10                      Right foot score:            /10

Comments

### General inspection

Mark areas of concern                      Comment on calluses, corns, fissures, verrucas, ulcers, rashes, wounds, or other structural deformities such as bunions, overlapping toes, hammer, claw, mallet, etc.





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## Foot Care Services treatment

**Narrative notes** (include details pertaining to treatments; e.g., corn reduction, callus reduction, nail reduction, verruca reduction, plantar surface filed, heels filed, temporary off-loading applied)

## Recommendations and plan

Estimated length of service	<input type="checkbox"/> One-time service	<input type="checkbox"/> Short-term service: up to 6 months	<input type="checkbox"/> Long-term service: more than 6 months
Recommended frequency of Foot Care Services One visit every _____ weeks			
Comments (as needed for clarification of the service recommendation stated above)			
Service goal (describe specific goal and expected outcome)			

## Discharge information (if applicable)

Select one only and include date (yyyy-mm-dd)	
<input type="checkbox"/> Estimated discharge date (for initial assessment or progress report)	<b>or</b> <input type="checkbox"/> Actual discharge date (for discharge report)

## Additional information

Recommended referrals and comments (e.g., primary care practitioner, podiatrist, pedorthist, wound care specialist, social worker)



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

Foot Care Services assessment and treatment completed by <small>(first and last name)</small>	Title <small>(nursing designation)</small>	Contact phone number	Next scheduled Foot Care Services visit <small>(yyyy-mm-dd)</small>
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**Claims Call Centre**

Phone 604.231.8888  
Toll-free 1.888.967.5377  
M-F, 8 a.m. to 6 p.m.

**Fax**

604.233.9777  
Toll-free 1.888.922.8807

**Mail**

WorkSafeBC  
PO Box 4700 Stn Terminal  
Vancouver BC V6B 1J1

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