WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

RESET

RESIDENTIAL CARE SERVICES
CLINICAL CARE PLAN

Initial care plan ❒ **Revised care plan** ❒

Date *(yyyy-mm-dd)*

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
Address line 1		Address line 2	
City	Province/State	Country *(if not Canada)*	Postal code/Zip
Phone number *(please include area code)*	Extension	Birthdate *(yyyy-mm-dd)*	

Goals

Care plan

1. **Bathing**	Independent ❒	Dependent ❒	Requires assistance ❒
Client able to			
Requires			
2. **Shaving/oral care**	Independent ❒	Dependent ❒	Requires assistance ❒
Client able to			
Requires			
3. **Hair/skin**	Independent ❒	Dependent ❒	Requires assistance ❒
Client able to			
Requires			
4. **Dressing**	Independent ❒	Dependent ❒	Requires assistance ❒
Client able to			
Requires			

Additional information can be recorded on page 3.

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Residential Care Services Clinical Care Plan *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number

Care plan *(continued)*

5. **Toileting**

a) Bladder — Client able to

Requires

Cleaning of equipment/supplies done by

b) Bowel — Client able to

Requires

Cleaning of equipment/supplies done by

6. **Eating/meal preparation** Independent ❒ Dependent ❒ Requires assistance ❒

Client able to

Requires

7. **Transfers/mobility/positioning** Independent ❒ Dependent ❒ Requires assistance ❒

Client able to

Requires

8. **Exercise/ROM/stretching** *(please describe)*

9. **Appointments/activities**

10. **Special tasks** Tracheotomy ❒ Medications ❒ Tube feed ❒ Mechanical ventilation ❒ Colostomy ❒ Dressings/ treatments ❒

11. **Special instructions in the event of an emergency** *(please provide detailed instructions)*

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Residential Care Services Clinical Care Plan
(continued)

Worker last name	First name	Middle initial	WorkSafeBC claim number

Contact information

Name of worker's next of kin	Phone number *(please include area code)*
Emergency contact	Phone number *(please include area code)*
Family doctor	Phone number *(please include area code)*
WorkSafeBC officer	Phone number *(please include area code)*
Provider	Phone number *(please include area code)*

Care plan completed by

Name *(please print)*	Signature
Contact phone number *(please include area code)*	Copy in home ❒ Copy to WorkSafeBC ❒ Copy to agency ❒

Additional information

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.