WorkSafeBC

Hand Therapy Program Report

Reset

Please complete this report and submit it using the **WorkSafeBC Provider Portal**. To complete this form digitally, you must use **Adobe Acrobat Reader**. Please save your completed form before submitting it.

Number of pages submitted: 6

Report type (check one only)

☐ 83D293 Hand Therapy Assessment	☐ 83D358 Hand Therapy Extension Report	☐ 83D295 Hand Therapy Discharge Report
Report due within 3 days of completing assessment Date of service (first day of assessment) (yyyy-mm-dd)	Report due 1 week (5 business days) before end of current block Date of service (last day of treatment prior to this extension) (yyyy-mm-dd) Extension block #	Report due within 3 days of discharge date Date of service (date of discharge) (yyyy-mm-dd)

Worker and claim information

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

Area(s) and nature of injury accepted on this claim	Bilateral upper extremity injuries ☐ Yes ☐ No	Date of injury (yyyy-mm-dd)

Claim owner's name and job title	Primary care provider (e.g., attending physician or nurse practitioner)

Jobsite visit(s)

Are one or more jobsite visits indicated?

☐ Yes ☐ No

If yes, is the hand therapy provider able to complete the jobsite visit(s)? ☐ Yes ☐ No	If no, please explain

Return-to-work (RTW) planning and coordination

Is RTW planning and coordination indicated?

☐ Yes ☐ No

If yes, is the hand therapy provider able to complete the RTW planning and coordination? ☐ Yes ☐ No	If no, please explain

Plan and recommendations

Treatment goals (specific, measurable goals to be achieved by the end of the treatment or extension period)

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Treatment plan (i.e., type of treatment, exercise progression)

Expected duration of treatment and treatment frequency (average number of visits per week)

Based on current functional abilities, can modified or regular duties be performed concurrently with hand therapy treatment?

Regular duties ☐ Yes ☐ No

Modified duties ☐ Yes ☐ No

If no to both, please explain and include a possible date that modified duties could begin (yyyy-mm-dd)

Additional comments

RTW summary and recommendations

Refer to RTW plan?

☐ Yes ☐ No

If no, please comment on available modified hours and/or duties that would be appropriate for the worker

RTW considerations (if applicable)

Have the plan, recommendations, and any RTW considerations (when applicable) been communicated to the WorkSafeBC claim owner?

☐ Yes ☐ No ☐ Not yet

Note: The hand therapy provider must contact the WorkSafeBC claim owner as soon as any changes to the treatment plan are identified that affect the length or outcome of the treatment or RTW plan or that provide recommendations for other interventions.

Discharge information

Select one only and include date (yyyy-mm-dd)

☐ Estimated discharge date (for assessment report)

or

☐ Actual discharge date (for discharge report)

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Select one only and include status

☐ Estimated discharge status:

- ☐ Able to RTW
- ☐ Able to RTW with considerations
- ☐ Other

(see report for full details)
Discharge categories are defined in the *Hand Therapy Services Reference Manual*.

or

☐ Actual discharge status:

- ☐ Able to RTW
- ☐ Able to RTW with considerations
- ☐ Other

(see report for full details)
Discharge categories are defined in the *Hand Therapy Services Reference Manual*.

Note: The hand therapy provider must contact the WorkSafeBC claim owner no fewer than 5 business days prior to the injured worker's discharge date to confirm discharge status.

Participation

Referral date (yyyy-mm-dd)	Day 1 date (assessment date) (yyyy-mm-dd)
RTW start date (if plan has started) (yyyy-mm-dd)	Number of jobsite visits completed in the Hand Therapy Program (if any)

Program participation days (please write the actual number of days the worker attended in either the treatment block or extension block)

day(s)

Date(s) and reasons for any absence(s)

Level and nature of participation to date

Assessment findings

Mechanism and history of injury, including dates and surgeries (if applicable)

Subjective findings summary

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Clinical/objective findings summary
Include norms and comparison to opposite hand/arm when indicated; on discharge report, provide comparisons to initial assessment findings

Observations
ROM and biomechanical analysis
Strength
Neurological
Special test/other

Additional job details and/or brief job description (clarification to the table below, if required)

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Status of critical job demands

Identify critical job demands in relation to RTW (first column) and assess and provide details of current functional ability in relation to those job demands (second column).

Critical job demands (provide details of job requirements)	**Current functional ability** (provide measure)	**Job match?**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Recovery and RTW factors (if applicable)

Additional comments

Employer and job information

Company's name	Contact's name	Contact's job title
Contact's phone number	Worker's occupation	

Current attachment to pre-injury job

☐ Job attached

☐ Not job attached

☐ Not yet confirmed

Usual pre-injury work schedule (days and hours)

Days per week

Hours per day

Break schedule

Comments (if applicable)

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Are light or modified duties available?	Is worker currently working?
☐ Yes ☐ No ☐ Not yet confirmed	☐ Yes ☐ No ☐ Modified duties/hours

Provider's information

Certified hand therapist's name		Clinic's name		
Payee number	Clinic's email (optional)	Clinic's phone number	Clinic's fax number	
Mailing address		City	Province	Postal code

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

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