✓ To fill in and save this PDF, use Adobe Acrobat Reader XI or later.

Occupational Therapy Initial Report

Lock

If applicable, please select the Lock button before submitting the form.
Please note: once the Lock button has been selected, the form will no longer be editable.

INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

CLIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER

Assessment

DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)

DATE OF REFERRAL (dd/mmm/yyyy)

Medical and Rehabilitation Information

1. DIAGNOSIS:

2. CURRENT MEDICAL STATUS/UPDATE:

3. IS THE CLIENT CURRENTLY TAKING MEDICATION THAT IS CLAIM-RELATED?
○ Yes ○ No

IF YES ON QUESTION 3, SPECIFY SOURCE:
☐ Prescription bottle review
☐ Client report

IF YES ON QUESTION 3, SPECIFY CURRENT MEDICATION:

4. COMPLETED/PENDING MEDICAL INVESTIGATIONS:

5. DOES THE CLIENT CURRENTLY HAVE ANY MEDICAL RESTRICTIONS?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

6. IS THE CLIENT CURRENTLY USING ANY REHABILITATION SERVICES?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

7. DID THE CLIENT USE ANY REHABILITATION SERVICES PREVIOUSLY?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

Subjective Assessment — Client Interview

8. SYMPTOMS/CONCERNS:

9. SOCIAL SUPPORT:

10. CLIENT REPORT OF PRE-ACCIDENT FUNCTION:

11. CLIENT/COLLATERAL GOALS OF TREATMENT:

Objective Assessment

12. SYMPTOM PRESENTATION

○ Yes ○ No

IF YES, SELECT AT LEAST ONE SYMPTOM PRESENTATION:

☐ Pain ☐ Headaches ☐ Noise/light sensitivity ☐ Fatigue/sleep disturbance
☐ Dizziness ☐ Nausea ☐ Paresthesia/altered sensation ☐ Other :_____

13. ADDITIONAL INFORMATION:

PERFORMANCE COMPONENT

14. PHYSICAL LIMITATIONS

○ Yes ○ No

If 'No' on Question 14, skip to Question 20

15. IF YES, SELECT AT LEAST ONE PHYSICAL LIMITATION:

☐ ROM ☐ Strength ☐ Balance ☐ Coordination ☐ Other :_____

16. PROVIDE ADDITIONAL INFORMATION ABOUT PHYSICAL LIMITATIONS:

17. LIMITATIONS AFFECTING FUNCTIONAL ABILITY

○ Yes ○ No

If 'No' on Question 17, skip to Question 20

18. IF YES, SELECT AT LEAST ONE:

☐ Lifting/Carrying ☐ Pushing/pulling ☐ Reaching ☐ Hand function ☐ Postural tolerances ☐ Standing
☐ Sitting ☐ Stooping ☐ Sustained neck flexion

19. PROVIDE ADDITIONAL INFORMATION ABOUT LIMITATIONS AFFECTING FUNCTIONAL ABILITY:

20. COGNITIVE LIMITATIONS

○ Yes ○ No

If 'No' on Question 20, skip to Question 26

21. IF YES, SELECT AT LEAST ONE COGNITIVE LIMITATION:

☐ Attention ☐ Initiation ☐ Visual scanning/perception ☐ Awareness ☐ Executive function ☐ Other :_____

22. PROVIDE ADDITIONAL INFORMATION ABOUT COGNITIVE LIMITATIONS:

23. LIMITATIONS AFFECTING FUNCTIONAL ABILITY

○ Yes ○ No

If 'No' on Question 23, skip to Question 26

24. IF YES, SELECT AT LEAST ONE LIMITATION AFFECTING FUNCTIONAL ABILITY

☐ Multi-tasking ☐ Planning/organization ☐ Problem-solving/decision-making
☐ Frustration tolerance ☐ Communication skills ☐ Safety/judgment

25. PROVIDE ADDITIONAL INFORMATION ABOUT LIMITATION AFFECTING FUNCTIONAL ABILITY:

26. PSYCHOSOCIAL/BEHAVIOURAL LIMITATIONS

○ Yes ○ No

If 'No' on Question 26, skip to Question 30

27. IF YES, SELECT AT LEAST ONE PSYCHOSOCIAL/BEHAVIOURAL LIMITATION:

☐ Anxiety ☐ Mood ☐ Frustration tolerance ☐ Social avoidance/isolation ☐ Other :_____

28. PROVIDE ADDITIONAL INFORMATION ABOUT PSYCHOSOCIAL/BEHAVIOURAL LIMITATIONS:

29. LIMITATIONS AFFECTING FUNCTIONAL ABILITY

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

FUNCTIONAL STATUS

ADL

30. MOBILITY/TRANSFERS: IS CLIENT ABLE TO PERFORM ON THEIR OWN?

○ Yes ○ No

IF NO, SELECT:

☐ Requires extra time/equipment
☐ Requires assistance

IF NO, PROVIDE ADDITIONAL INFORMATION:

31. SELF-CARE: IS CLIENT ABLE TO PERFORM ON THEIR OWN?

○ Yes ○ No

IF NO, SELECT:

☐ Requires extra time/equipment
☐ Requires assistance

IF NO, PROVIDE ADDITIONAL INFORMATION:

IADL

32. HOUSEHOLD MANAGEMENT: IS THE CLIENT ABLE TO PERFORM ON THEIR OWN?

○ Yes ○ No

IF NO, SELECT:	IF NO, PROVIDE COMMENTS:
☐ Requires extra time/equipment ☐ Requires assistance	

TRANSPORTATION

33. PRE-ACCIDENT:

34. CURRENT:

LEISURE

35. PRE-ACCIDENT:

36. CURRENT:

ENVIRONMENT/ACCESSIBILITY

37. ARE THERE ENVIRONMENT/ACCESSIBILITY BARRIERS?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

OTHER

38. OTHER FUNCTIONAL STATUS:

Work Status

39. IS THE CLIENT STILL JOB ATTACHED?
○ Yes ○ No

40. IS THE CLIENT EMPLOYED OR ENGAGED IN TRAINING ACTIVITIES? PLEASE INDICATE WHICH ONE(S)
☐ Full time ☐ Part time ☐ Self-employed ☐ Seasonal ☐ Training/Apprenticeship ☐ Student ☐ Retired ☐ Not employed

41. HAS THE CLIENT BEEN ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?
Work: ○ Yes ○ No Training: ○ Yes ○ No School/Studies: ○ Yes ○ No

If the client is continuing to work, study or train indicate their status, as applicable

42. STATUS OF DUTIES
Work: ○ Full ○ Modified Training: ○ Full ○ Modified Study: ○ Full ○ Modified

43. STATUS OF HOURS
Work: ○ Full ○ Modified Training: ○ Full ○ Modified Study: ○ Full ○ Modified

44. CRITICAL JOB DEMAND 1	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 2	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 3	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 4	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 5	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 6	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 7	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 8	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 9	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 10	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 11	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 12	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 13	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 14	ABLE TO MEET ○ Yes ○ No
CRITICAL JOB DEMAND 15	ABLE TO MEET ○ Yes ○ No

45. IS RETURN TO WORK A GOAL OF REHABILITATION AT THIS TIME?
○ Yes ○ No

IF NO, PROVIDE COMMENTS:

46. IS EMPLOYER ABLE TO ACCOMMODATE GRADUAL RETURN TO WORK?
○ Yes ○ No ○ To be determined

Barriers to Return to Function/Return to Work

47. FUNCTIONAL
○ Yes ○ No

IF YES, PROVIDE COMMENTS:

48. VOCATIONAL
○ Yes ○ No

IF YES, PROVIDE COMMENTS:

49. MEDICAL

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

50. ENVIRONMENTAL

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

51. OTHER:

Summary/Analysis

52. SUMMARY/ANALYSIS:

Therapy Treatment Goals

53. ANTICIPATED PROGRAM OUTCOME:

GOAL 1	
GOAL:	ACTION STEPS:

GOAL 2	
GOAL:	ACTION STEPS:

GOAL 3	
GOAL:	ACTION STEPS:

GOAL 4	
GOAL:	ACTION STEPS:

GOAL 5	
GOAL:	ACTION STEPS:

Recommendations

RETURN TO FUNCTION RECOMMENDATIONS (equipment, services, rehabilitation, other)
RECOMMENDATIONS

RETURN TO WORK RECOMMENDATIONS (equipment, services, rehabilitation, other) Fill this section if the client is NOT working or working modified duties/hours.
RECOMMENDATIONS

Report Distribution

REPORT DISTRIBUTED TO THE FOLLOWING TEAM MEMBERS	
☐ Family physician	
☐ Specialist	
☐ PT	
☐ Lawyer	
☐ Other	

Service Provider Information

CONTACT PREFERENCE	
☐ By phone	CONTACT PHONE NUMBER
☐ By email	CONTACT EMAIL

OT Program Cost Projection

START OF OT PROGRAM (dd/mmm/yyyy)	END OF OT PROGRAM (dd/mmm/yyyy)

SERVICE ITEM	ESTIMATED TIME
OT professional services	hours
Rehab assistant services	visits/week x hours/visit x weeks

Services will be monitored by OT on an ongoing basis to ensure effectiveness.

Expense item (purchased directly by OT only)	Amount	Pre-approved
	$	○ Yes ○ No
	$	○ Yes ○ No
	$	○ Yes ○ No
	$	○ Yes ○ No
	$	○ Yes ○ No

Additional Comments/Information

Additional Comments/Information (continued)

☐ By checking this box, I certify that the information provided is true and correct to the best of my knowledge.

Select one of the following:

☐ I have obtained consent from the client to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.

☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.