



Occupational Therapy Initial Report



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)			
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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? <input type="radio"/> Yes <input type="radio"/> No
IF YES ON QUESTION 3, SPECIFY SOURCE: <input type="checkbox"/> Prescription bottle review <input type="checkbox"/> Client report
IF YES ON QUESTION 3, SPECIFY CURRENT MEDICATION:
4. COMPLETED/PENDING MEDICAL INVESTIGATIONS:

5. DOES THE CLIENT CURRENTLY HAVE ANY MEDICAL RESTRICTIONS? <input type="radio"/> Yes <input type="radio"/> No
IF YES, PROVIDE COMMENTS:
6. IS THE CLIENT CURRENTLY USING ANY REHABILITATION SERVICES? <input type="radio"/> Yes <input type="radio"/> No
IF YES, PROVIDE COMMENTS:
7. DID THE CLIENT USE ANY REHABILITATION SERVICES PREVIOUSLY? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No	
IF NO, SELECT: <input type="checkbox"/> Requires extra time/equipment <input type="checkbox"/> Requires assistance	IF NO, PROVIDE COMMENTS:

TRANSPORTATION	
33. PRE-ACCIDENT:	
34. CURRENT:	

LEISURE	
35. PRE-ACCIDENT:	
36. CURRENT:	

ENVIRONMENT/ACCESSIBILITY	
37. ARE THERE ENVIRONMENT/ACCESSIBILITY BARRIERS? <input type="radio"/> Yes <input type="radio"/> 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	
<input type="checkbox"/> Family physician	
<input type="checkbox"/> Specialist	
<input type="checkbox"/> PT	
<input type="checkbox"/> Lawyer	
<input type="checkbox"/> Other	

Service Provider Information

CONTACT PREFERENCE	
<input type="checkbox"/> By phone	CONTACT PHONE NUMBER
<input type="checkbox"/> By email	CONTACT EMAIL

OT Program Cost Projection

START OF OT PROGRAM (dd/mmm/yyyy)	END OF OT PROGRAM (dd/mmm/yyyy)
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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
	\$	<input type="radio"/> Yes <input type="radio"/> No
	\$	<input type="radio"/> Yes <input type="radio"/> No
	\$	<input type="radio"/> Yes <input type="radio"/> No
	\$	<input type="radio"/> Yes <input type="radio"/> No
	\$	<input type="radio"/> Yes <input type="radio"/> 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 investigate, manage or settle a claim. Questions about the collection of this information may be directed to the adjuster, or call 604-661-2800 or contact the Privacy & Freedom of Information (FOI) Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.