Occupational Therapy Reassessment 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(S) OF ASSESSMENT			
(dd/mmm/yyyy)	(dd/mmm/yyyy)	(dd/mmm/yyyy)	(dd/mmm/yyyy)

DATE(S) OF TREATMENT SINCE LAST REPORT
(dd/mmm/yyyy)

Medical And Rehabilitation Information

1. CURRENT MEDICAL STATUS/UPDATE:
2. COMPLETED/PENDING MEDICAL INVESTIGATIONS:

Subjective Assessment — Client Interview

3. ONGOING SYMPTOMS/CONCERNS:

Objective Assessment

PERFORMANCE COMPONENT

4. PHYSICAL LIMITATIONS

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

5. COGNITIVE LIMITATIONS

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

6. PSYCHOSOCIAL/BEHAVIOURAL LIMITATIONS

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

FUNCTIONAL STATUS

ADL

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

○ Yes ○ No

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

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

○ Yes ○ No

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

IADL

9. 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

10. PRE-ACCIDENT:

11. CURRENT:

LEISURE

12. PRE-ACCIDENT:

13. CURRENT:

ENVIRONMENT/ACCESSIBILITY

14. ARE THERE ENVIRONMENT/ACCESSIBILITY BARRIERS?
○ Yes ○ No

IF YES, PROVIDE COMMENTS:

OTHER

15. OTHER FUNCTIONAL STATUS:

Work Status

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

17. 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

18. 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

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

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

21. 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

22. IS RETURN TO WORK A GOAL OF REHABILITATION AT THIS TIME?

○ Yes ○ No

IF NO, PROVIDE COMMENTS:

23. IS EMPLOYER ABLE TO ACCOMMODATE GRADUAL RETURN TO WORK?

○ Yes ○ No ○ To be determined

Summary/Analysis

24. SUMMARY/ANALYSIS:

Therapy Treatment Goals

25. 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

☐ 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.