

P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: (780) 427-5863
1-800-661-1993

OCCUPATIONAL THERAPY SERVICES

Personal Care Allowance Assessment

- Initial Assessment
 Re-Assessment/Follow-up

Please print clearly or type.

			WCB Claim Number	Date of Accident (yyyy/mm/dd)
Worker's Surname	First Name	Initial	Date of Birth (yyyy/mm/dd)	
Address Street	City/Town	Province	Postal Code	Telephone Number ()
Referral Source Name	Referral Source Contact Telephone Number ()		Referral Date (yyyy/mm/dd)	
Provider Contact Name	Provider Contact Telephone Number ()		Assessment Date (yyyy/mm/dd)	

GENERAL

MOBILITY

PERSONAL HYGIENE

DRESSING

FEEDING

MEDICAL OR PARA-MEDICAL REQUIREMENTS

SUPERVISION

MENTAL STATUS

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Worker's Surname	First Name	<i>(Initial)</i>	Claim Number
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LIVING SITUATION

HOMEMAKING SERVICES

TRANSPORTATION

VEHICLE

BANKING

SELF-MANAGED CARE

VOCATIONAL

RECREATION

AIDS AND EQUIPMENT

ADDITIONAL INFORMATION

GENERAL RECOMMENDATIONS

Worker's Surname	First Name	(Initial)	Claim Number
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If you have any questions regarding the information or would like to discuss, please contact the undersigned.

Provider's Name

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Contact Telephone Number

Date (yyyy/mm/dd)

Worker's Surname	First Name <i>(Initial)</i>	Claim Number
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DAILY REPORT

Please indicate general occurrences for each hour. Include meals and amounts, bowel movements, sleep, procedures, therapies, recreation activities, baths, bed changing, medical or behavioral events, and so forth. There is room at the end to add comments or elaborate on an event.

5:00 a.m.

6:00 a.m.

7:00 a.m.

8:00 a.m.

9:00 a.m.

10:00 a.m.

11:00 a.m.

12:00 a.m.

1:00 p.m.

2:00 p.m.

3:00 p.m.

4:00 p.m.

5:00 p.m.

6:00 p.m.

7:00 p.m.

8:00 p.m.

9:00 p.m.

10:00 p.m.

11:00 p.m.

12:00 a.m.

1:00 a.m.

2:00 a.m.

3:00 a.m.

4:00 a.m.

Comments: