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OCCUPATIONAL THERAPY SERVICES

New Vehicle Modification 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)	

ASSESSMENT SUMMARY

This questionnaire is designed to help assess the injured worker's needs for vehicle transportation. It will also assist in the selection of specific equipment and adaptations needed, as well as the vehicle required to accept these modifications.

Nature of Permanent Compensable Disability

- Paraplegic Level Complete Yes No
 Quadriplegic Level Complete Yes No
 Hemiplegic Left Arm Left Leg Right Arm Right Leg
 Amputee - Describe:
 Brain Injury
 Other

Please describe functional abilities related to driving (sitting balance, hand function, vision, and attention). Please attach any additional pertinent information:

Current Transportation

- Worker owns a vehicle Yes No
 Worker uses public accessible transportation service Yes No
 Worker drives an unadapted vehicle Make: Model: Year:
 Worker drives an adapted vehicle Make: Model: Year:

Type of adaptations on the current vehicle (please check all equipment used):

- Hand controls Spinner knob Left foot gas Power/remote doors
 Right hand signal Six-way seat Remote starter Lowered floor
 Raised roof Raised door

Wheelchair lift Type: Age:

Other specialized adaptive equipment:

The above equipment was installed by: Date:

Date of last vehicle modification:

Has the worker had an adapted driving assessment? Yes No If yes, attach a copy of the assessment.

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Recommendations for New Modified Vehicle

Does the worker have a valid driver's license? Yes No

Do the primary drivers have a valid driver's license? Yes No

WCB may provide items as medically required. Extra options chosen will be paid for by the client.

Mini van Full sized van Truck Other: Rationale:

Worker's preferred vehicle (make, type, year & color):

Remote start, Rationale:

Air conditioning: Front: Yes No Back: Yes No Rationale:

Running boards, Rationale:

Handbrake, Rationale:

Lowered floor, Please specify:

Raised roof, Please specify:

Left foot controls, Please specify:

Hand controls, Please specify:

Right hand signal, Please specify:

Wheelchair lift, Please specify:

Spinner knob, Please specify:

Six way seat, Please specify:

Left foot gas, Please specify:

Raised door, Please specify:

Truck box canopy, Rationale:

Privacy glass, Rationale:

Generator/Battery, Rationale:

▪ Type of Switches Magnetic Radio Dashboard Toggle

▪ Transmission: Automatic Standard Rationale:

▪ Lock: Remote Keyless Entry Keys Rationale:

▪ Windows: Tinted Clear Rationale:

▪ Door option: Rationale:

▪ Type of seats front and back: Rationale:

▪ Type of fuel: Rationale:

▪ Interior width of vehicle:

▪ Area behind driver's seat length:

▪ Front seat:

▪ Head clearance:

▪ Foot room:

▪ Is there a preferred dealer for the vehicle modifications? (if any)

Functional Use of the New Modified Vehicle

▪ Specify any other customization needed and rationale:

How does the worker want to use this new vehicle:

▪ Drive to/from work? Yes No

▪ Does the worker want to drive this vehicle? Yes No

▪ Who will be the primary driver(s) of this vehicle?

▪ Who else will drive the vehicle?

▪ Will an attendant be with the worker at all times when travelling in the vehicle? Yes No

▪ What locations (any or all) will the worker want to be in the vehicle when in the wheelchair?

Driver Front Passenger Middle Rear

▪ Number of people travelling in vehicle: Adults: Children (# & ages):

▪ How often will the vehicle be driven?

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Worker's Surname	First Name	(Initial)	Claim Number
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Other Considerations

- Will the vehicle be parked:

Outside	<input type="checkbox"/>	At Home	<input type="checkbox"/>	At Work
In Garage	<input type="checkbox"/>	At Home	<input type="checkbox"/>	At Work
Carport	<input type="checkbox"/>	At Home	<input type="checkbox"/>	At Work
Parkade	<input type="checkbox"/>	At Home	<input type="checkbox"/>	At Work
- What is height clearance of garage door?

At Home	<input type="checkbox"/>	At Work	<input type="checkbox"/>
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- What is the area available on the exiting side of the vehicle for the worker to load/unload in a wheelchair?

At Home	<input type="checkbox"/>	At Work	<input type="checkbox"/>
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 Which side is it?

<input type="checkbox"/>	Driver's side	<input type="checkbox"/>	Passengers' side	<input type="checkbox"/>	Rear
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- What type of roads does the worker **normally** travel? Ground clearance can be important on some adapted vehicles.

Paved:	<input type="checkbox"/>	Gravel:	<input type="checkbox"/>	Combination:	<input type="checkbox"/>
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- Does the worker have other vehicle needs (e.g. 4x4, pulling a trailer or boat)?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes, please specify:
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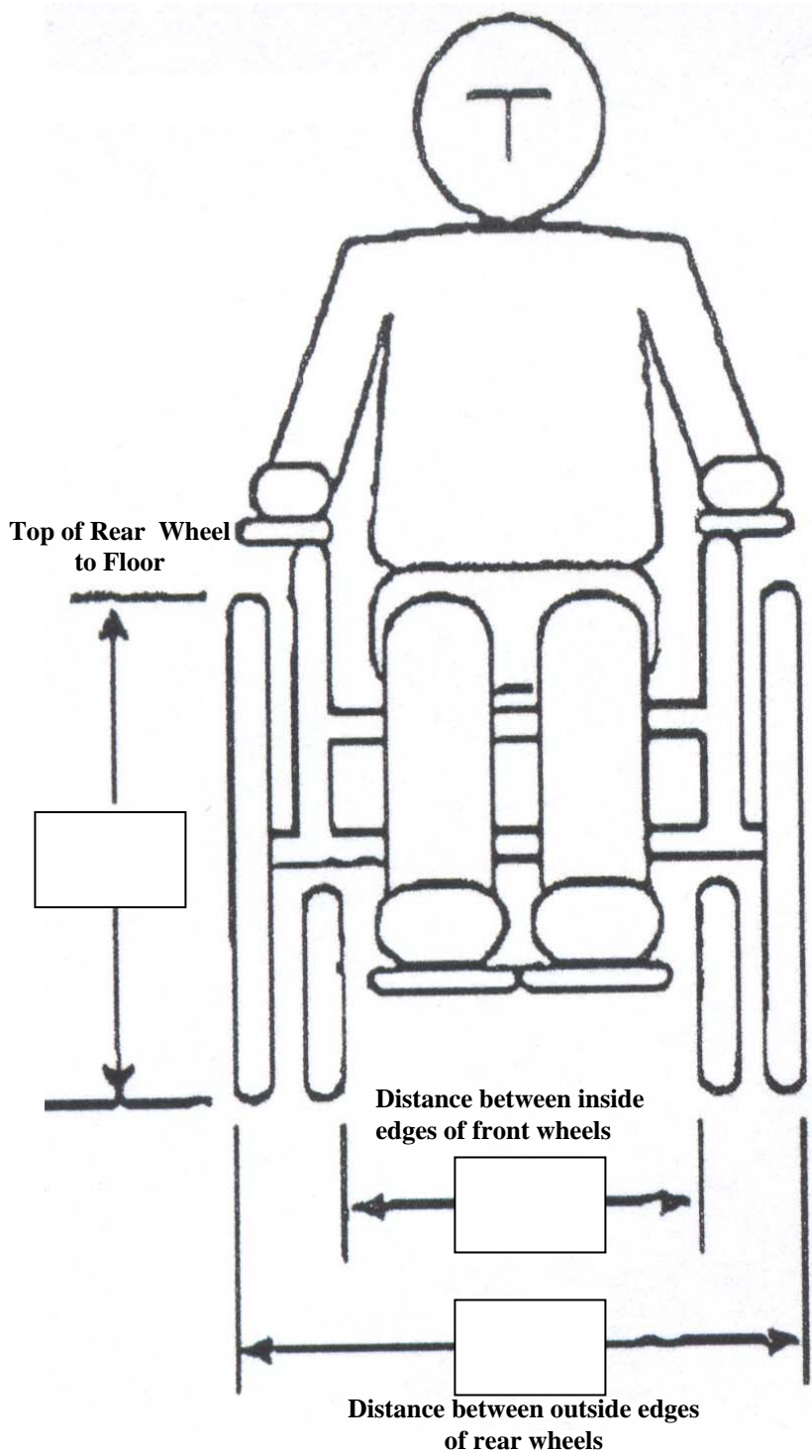
Worker's Surname

First Name

(Initial)

Claim Number

Worker Wheelchair Information Continued



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

Worker's Signature

Date (yyyy/mm/dd)

Provider's Name

()

Contact Telephone Number

Date (yyyy/mm/dd)