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| **Occupational Therapy**  **Initial Assessment** | **Surname:**  **Given Name:**  **DOB:\_\_\_\_\_\_ Sex:\_\_\_ Claim No.:\_\_\_\_\_\_\_\_**  **Address:** |

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**CLAIM ANT DETAILS**

**Claim No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of injury:** \_\_\_\_\_\_\_\_\_\_\_\_

**Injury:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Assessment:** \_\_\_\_\_\_\_\_\_\_\_\_

**Present at Assessment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF REPORT**:

**RELEVANT PAST MEDICAL HISTORY**

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**CLIENT’S LONG TERM GOALS**

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**PRE-MORBID FUNCTIONAL LEVEL AND LIFE ROLE**

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| --- |
| **Initial Assessment** |
|  |
| C:\Users\miboujaoude\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\UZI7FHBI\42_as_Interleaved_2_of_5_barcode[1].jpg |
|  |

**Pre-morbid Work Status** Employed (Full time / part time/ casual) € Retired € Terminated /Date:\_\_\_\_\_

€ training or retraiing; course\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Employer’s Contacts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Position held:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed since:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Annual Rate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_  
Hours/week:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Days worked:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Breaks:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Access issue\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DUTIES PREVIOUSLY PERFORMED:**

|  |  |  |
| --- | --- | --- |
| Duties | Critical tasks demands | Frequency / duration |
|  |  |  |

**Previous return to work attempted**

Return to Work € Yes / no

|  |  |
| --- | --- |
| Return to Work Date |  |
| Restrictions |  |
| Duties |  |

previous Work site visit completed € yes/no

Previous Job capacity evaluation: Date: \_\_\_\_\_\_\_\_\_\_\_\_  
Outcome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT STATUS**

**Cognitive**

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**Psychosocial**

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**Physical/Functional mobility / positional tolerance self-care**

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**Domestic tasks**

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**Community /driving**

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**Support in place**

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**INTERIM OBJECTIVES OF RETURN TO WORK (RTW) PROGRAM**

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| **Worksite Assessment – Include description of pre - injury duties, hours and suitable duties identified** | |
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| **Identified Barriers and Proposed Solutions** | |
| **Barriers** | **Solutions** |
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**RECOMMENDATIONS FOR RETURN TO WORK PROGRAM**

|  |  |
| --- | --- |
| Restrictions |  |
| suitable Duties |  |

**RETURN TO WORK PLAN**

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**ACCESS TO WORK**

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**ACCESS TO CLIENTS DURING WORKING HOURS**

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**Please note that the recommendations are subject to ongoing medical advice.**

**THERAPIST’S SIGNATURE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

Name

Occupational Therapist