WorkplaceNL

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CBOR Reporting
☐ Initial
☐ Progress
☐ Discharge

CLINIC-BASED OCCUPATIONAL REHABILITATION

CLIENT INFORMATION

P.O. NUMBER	CLAIM NUMBER
SURNAME	GIVEN NAME(S)
OCCUPATION TARGETED	DATE REFERRAL RECEIVED (YY / MM / DD) | DATE WORKER ASSESSED (YY / MM / DD)

TARGETED TOLERANCES	Initial status Date ____ YY MM DD						Current / discharge status Date ____ YY MM DD						Targeted CBOR goals Date ____ YY MM DD				
	N	**S**	**M**	**O**	**F**	**C**	**N**	**S**	**M**	**O**	**F**	**C**	**S**	**M**	**O**	**F**	**C**

SUMMARY (To be completed for all Initial, Progress and Discharge Reports.)

Date of Report ____ YY MM DD

A. Degree of strenuousness (NOC) _____

B. Estimated workday tolerance _____

C. List of physical restrictions _____

Frequency Rating	Code	8hrs shift
Not Able	NA	0
Seldom - not daily	S	0
Minor 0-10% of shift	M	<1hr
Occasional 11-33% of shift	O	1-2hrs
Frequent 34-66% of shift	F	2.5-5hrs
Constant 67-100% of shift	C	>5hrs

PROGRESS

Number of weeks since start of CBOR program:_____ Number of CBOR sessions attended to date:_____

Number of sessions missed to date:_____ Are you recommending continuation of CBOR? ☐ YES ☐ NO

If yes, indicate number of sessions _____ Will the worker need an extension to the original CBOR plan: ☐ YES ☐ NO

Worker's Name: _____ **Claim #:** _____

PLAN: to be completed for all initial and Progress Reports

Week _____ Dates:_____ Number sessions/week:_____ Week _____ Dates: Number sessions/week:_____

Week _____ Dates:_____ Number sessions/week:_____ Week _____ Dates: Number sessions/week:_____

Week _____ Dates:_____ Number sessions/week:_____ Week _____ Dates: Number sessions/week:_____

Week _____ Dates:_____ Number sessions/week:_____ Week _____ Dates: Number sessions/week:_____

Original targeted completion date _____ Revised targeted completion date _____

COMMENTS: _____

DISCHARGE

Discharge Date:_____ Total number of sessions completed:_____ Total number of weeks:_____

CLINIC SERVICE PROVIDER VENDOR # _____

CLINIC NAME: _____

ATTENDING LICENSED PRACTITIONER # _____

PHONE NUMBER: _____

NAME (Print) _____ SIGNATURE _____ DATE _____
YY MM DD