



**B - DISABLING CONDITION (cont'd)**

2. How does your disability affect your life and your ability to take care of yourself?

Sample

**B - DISABLING CONDITION (cont'd)**

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**C - DECLARATION AND NOTIFICATION**

I, \_\_\_\_\_, am applying to confirm my continuing eligibility for designation as a person with disabilities as set out in the *Employment and Assistance for Persons with Disabilities Act* and I declare that the information provided in Section 1A and 1B is true and complete. I understand that I will have the opportunity to review completed Section 2, Physician Report and Section 3, Assessor Report before submitting the completed designation review form to the Ministry of Human Resources. I understand that the BC government may verify the information in Section 1A, Section 2 and Section 3, as necessary to determine and confirm my continuing eligibility for that designation.

\_\_\_\_\_  
\*Client Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date Signed (YYYY MMM DD)

\_\_\_\_\_  
Witness Name (Please Print)

\_\_\_\_\_  
Witness Address & Telephone

can be  
any  
adult

\* If the Client is incapable of signing this Review Form, it may be signed by a person who has legal authority to act on behalf of the Client as applicable under provisions of relevant BC legislation, for example, a committee, or a person with an enduring power of attorney. If you are signing on behalf of the Client, you must state your legal authority to act on behalf of the Client and you must attach proof of that legal authority (for example, a copy of the court order naming you as Committee) to this Review.

My legal authority to act for the client is \_\_\_\_\_.

**NOTE: Proof of Committee, Power of Attorney and/or Parent/Guardian status must accompany this Review Form.**

**TO BE COMPLETED BY THE CLIENT'S PHYSICIAN ONLY**

<b>A - DIAGNOSES</b>				
Specify diagnoses <u>related to the Client's impairment</u> using the diagnostic codes below. "Impairment" is a loss or abnormality of psychological, anatomical or physiological structure or function causing a restriction in the ability to function independently, effectively, appropriately or for a reasonable duration. Please include additional information as required.				<b>Date of onset, If known</b>
	<b>Diagnostic Code</b>	<b>Specific Diagnosis</b> (e.g. location of paralysis, type of respiratory or heart condition, type of hepatitis, etc.)	<b>Month</b>	<b>Year</b>
1.				
2.				
3.				
4.				
5.				
<b>Comments:</b>				

**DIAGNOSTIC CODES**

**Infectious and parasitic diseases**

- 1.0 Other
- 1.1 HIV
- 1.2 AIDS
- 1.3 Hepatitis
- 1.4 Hepatitis C

**Neoplasms**

- 2.0 Neoplastic disorders - other
- 2.1 Lip, oral cavity & pharynx
- 2.2 Digestive organs & peritoneum
- 2.3 Respiratory & intrathoracic organs
- 2.4 Bone, connective tissue, skin and breast
- 2.5 Genitourinary organs
- 2.6 Leukemia

**Endocrine, nutritional and metabolic diseases, and immunity disorders**

- 3.0 Endocrine disorders - other
- 3.01 Immune disorders - other
- 3.02 Metabolic disorders - other
- 3.1 Thyroid disorders
- 3.2 Diabetes

**Diseases of the blood and blood-forming organs**

- 4.0 Other diseases of the blood
- 4.1 Anemia
- 4.2 Hemophillia

**Mental disorders**

- 5.0 Other mental (please specify)
- 5.1 Delirium, dementia & amnesic & other cognitive disorders
- 5.2 Schizophrenia & other Psychotic disorders
- 5.3 Mood disorders
- 5.4 Developmental disability
- 5.5 Anxiety disorders
- 5.6 Somatoform disorders
- 5.7 Personality disorders
- 5.8 Substance-related disorders
- 5.9 Pervasive developmental disorders
- 5.10 Eating disorders

**Diseases of the nervous system & sense organs - Neurological**

- 6.0 Neurological disorders - other
- 6.1 Epilepsy
- 6.3 Brain tumors
- 6.4 Parkinson's disease
- 6.5 Cerebral palsy
- 6.6 Paraplegia
- 6.7 Quadraplegia
- 6.9 Other paralysis
- 6.10 Myasthenia Gravis
- 6.11 Muscular dystrophy
- 6.12 ALS
- 6.13 Alzheimer's disease
- 6.14 Huntington's Chorea
- 6.15 Friedreich's Ataxia
- 6.16 Multiple sclerosis

**Conditions of the nervous system & sense organs - Sensory**

- 7.00 Sensory disorders - other
- 7.01 Blindness
- 7.02 Visually impaired
- 7.03 Deafness
- 7.04 Hearing impaired
- 7.05 Organic speech loss

**Diseases of the circulatory system**

- 8.0 Cardiovascular - other
- 8.1 Ischemic heart disease
- 8.2 Recurrent Arrhythmias
- 8.3 Valvular heart disease
- 8.4 Congenital heart disease
- 8.5 Cardiomyopathy
- 8.6 Chronic venous insufficiency
- 8.7 Peripheral arterial disease
- 8.8 Cerebral vascular accident

**Diseases of the respiratory system**

- 9.0 Respiratory disorders - other
- 9.1 Cystic fibrosis
- 9.2 COPD
- 9.3 Asthma
- 9.4 Emphysema

**Diseases of the digestive system**

- 10.0 Digestive disorders - other
- 10.1 Peptic ulcer
- 10.2 Chronic liver disease
- 10.3 Cirrhosis
- 10.4 Crohn's disease
- 10.5 Colitis

**Diseases of the genitourinary system**

- 11.0 Genitourinary disorders - other
- 11.1 Kidney disease

**Diseases of the skin and subcutaneous tissue**

- 12.0 Skin disorders - other
- 12.1 Psoriasis

**Diseases of the musculoskeletal system and connective tissue**

- 13.0 Musculoskeletal system - other
- 13.1 Lupus
- 13.2 Rheumatoid arthritis
- 13.3 Arthritis
- 13.4 Osteoporosis
- 13.5 Ankylosing spondylitis
- 13.6 Degenerative disc disease
- 13.7 Scoliosis
- 13.8 Fibromyalgia
- 13.9 Scleroderma

**Congenital anomalies**

- 14.0 Congenital anomalies - other
- 14.1 Chromosomal abnormalities
- 14.2 Fetal alcohol syndrome
- 14.3 Thalidomide syndrome
- 14.4 Spina Bifida

**Injury and poisoning**

- 15.0 Injury and poisoning - other
- 15.1 Traumatic brain injury
- 15.2 Amputations

**Other conditions**

- 16.0 Other
- 16.1 Chronic fatigue syndrome
- 16.2 Sleep apnea
- 16.3 Environmental sensitivities

**B - HEALTH HISTORY**

1. Please indicate the severity of the medical conditions relevant to this person's impairment. How does the medical condition impair this person? Test results and other reports or findings may be used here where appropriate.

Handwritten area with multiple horizontal lines for notes. A large, diagonal watermark reading "Sample" is overlaid across this section.

2. Height and Weight (*if relevant to the impairment*)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

3. Has the client been prescribed any medication and/or treatments that interfere with his/her ability to perform daily living activities?  Yes  No

If yes, please explain:

Handwritten area with horizontal lines for explanation.

If yes, what is the anticipated duration of the medications/treatments:

Handwritten area with horizontal lines for duration.

4. Does the client require any prostheses or aids for his/her impairment?  Yes  No

If yes, please explain:

Handwritten area with multiple horizontal lines for explanation.

**C - DEGREE AND COURSE OF IMPAIRMENT**

1. Is the impairment likely to continue for two years or more from today?  Yes  No  
What is the estimated duration of the impairment and are there remedial treatments that may resolve or minimize the impairment?

Please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**D - FUNCTIONAL SKILLS**

Note: For the purposes of questions #1 and #2, "unaided" means without the assistance of another person, assistive device or assistance animal

1. How far can this person **walk** unaided on a flat surface?  
 4+ blocks  1 to 2 blocks  Unknown  
 2 to 4 blocks  Less than 1 block  Not at all

2. How many **stairs** can this person climb unaided?  
 5+ steps  2 to 5 steps  None  Unknown

3. What are the person's limitations in **lifting**?  
 No limitations  2 to 7 kg (5 to 15 lbs)  No lifting  
 7 to 16 kg (15 to 35 lbs)  Under 2 kg (Under 5 lbs)  Unknown

4. How long can this person remain **seated**?  
 No limitation  1 to 2 hours  Unknown  
 2 to 3 hours  Less than 1 hour

5. Are there difficulties with **communication** other than a lack of fluency in English?  Yes  No  
If yes, what is the cause:  Cognitive  Motor  Sensory  Other

Comments:

\_\_\_\_\_  
\_\_\_\_\_

6. Are there any significant deficits with **cognitive and emotional function**?  Yes  No  Unknown  
If yes, check those areas where the deficits are evident and provide details below:

- |   |  |
|---|--|
| <input type="checkbox"/> Consciousness ( <i>orientation, confusion</i> )                                | <input type="checkbox"/> Emotional disturbance ( <i>e.g. depression, anxiety</i> )                         |
| <input type="checkbox"/> Executive ( <i>planning, organizing, sequencing, calculations, judgement</i> ) | <input type="checkbox"/> Motivation ( <i>loss of initiative or interest</i> )                              |
| <input type="checkbox"/> Language ( <i>oral, auditory, written comprehension or expression</i> )        | <input type="checkbox"/> Impulse control   |
| <input type="checkbox"/> Memory ( <i>ability to learn and recall information</i> )                      | <input type="checkbox"/> Motor activity ( <i>goal oriented activity, agitation, repetitive behaviour</i> ) |
| <input type="checkbox"/> Perceptual psychomotor ( <i>visual spatial</i> )                               | <input type="checkbox"/> Attention or sustained concentration  |
| <input type="checkbox"/> Psychotic symptoms ( <i>delusions, hallucinations, thought disorders</i> )     | <input type="checkbox"/> Other ( <i>specify</i> ) _____  |

Comments:

\_\_\_\_\_  
\_\_\_\_\_

**E - DAILY LIVING ACTIVITIES**

Note: If you are completing the Assessor Report, Section 3, in addition to this Physician Report, do not complete this page, (Part E)

Does the impairment directly restrict the person's ability to perform Daily Living Activities?

Yes  No  Unknown

If yes, please complete the following table:

Daily Living Activities	Is Activity Restricted? (check one) If yes, describe extent of restriction in "comments" below			If yes, the restriction is: (check one)	
	Yes	No	Unknown	Continuous <sup>1</sup>	Periodic <sup>*2</sup>
Personal self care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basic housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility inside the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility outside the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social functioning** - daily decision making; interacting, relating and communicating with others (this category only applies for persons with an identified mental impairment or brain injury). If yes, please provide details	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* If "Periodic", please explain:

\*\* If Social Functioning is impacted, please explain:

Please provide additional comments regarding the degree of restriction:

What assistance does your patient need with Daily Living Activities? ("Assistance" includes help from another person, equipment and assistance animals.) Please be specific regarding the nature and extent of assistance required.

<sup>1</sup> **Continuous assistance** - refers to needing significant help most or all of the time for an activity.

<sup>2</sup> **Periodic assistance** - refers to the need for significant help for an activity some of the time as would be the case where a person required help due to the episodic nature of the impairment.



**A - LIVING ENVIRONMENT**

1. Does the Client live  Alone?  With Family, Friends, or Caregiver?  In a Care Facility?

Comment:

**B - MENTAL OR PHYSICAL IMPAIRMENT**

"Impairment" is a loss or abnormality of psychological, anatomical or physiological structure or functioning causing a restriction in the ability to function Independently, effectively, appropriately or for a reasonable duration.

1. What are the client's mental or physical impairments that impact his/her ability to manage Daily Living activities? (brief summary)

2. Ability to Communicate

Please indicate the level of ability in the following areas:

Good

Satisfactory

Poor

Unable

Explain / Describe

Speaking

Reading

Writing

Hearing

Comments:

3. Mobility and Physical Ability

Indicate the assistance required related to impairment(s) that directly restrict the client's ability to manage in the following areas. Check all that apply.

Independent

Periodic assistance <sup>1</sup> from another person

Continuous assistance <sup>2</sup> from another person or unable

Uses Assistive device

Takes significantly longer than typical (describe how much longer)

Explain and specify assistive device/s

Walking indoors

Walking outdoors

Climbing stairs

Standing

Lifting

Carrying and holding

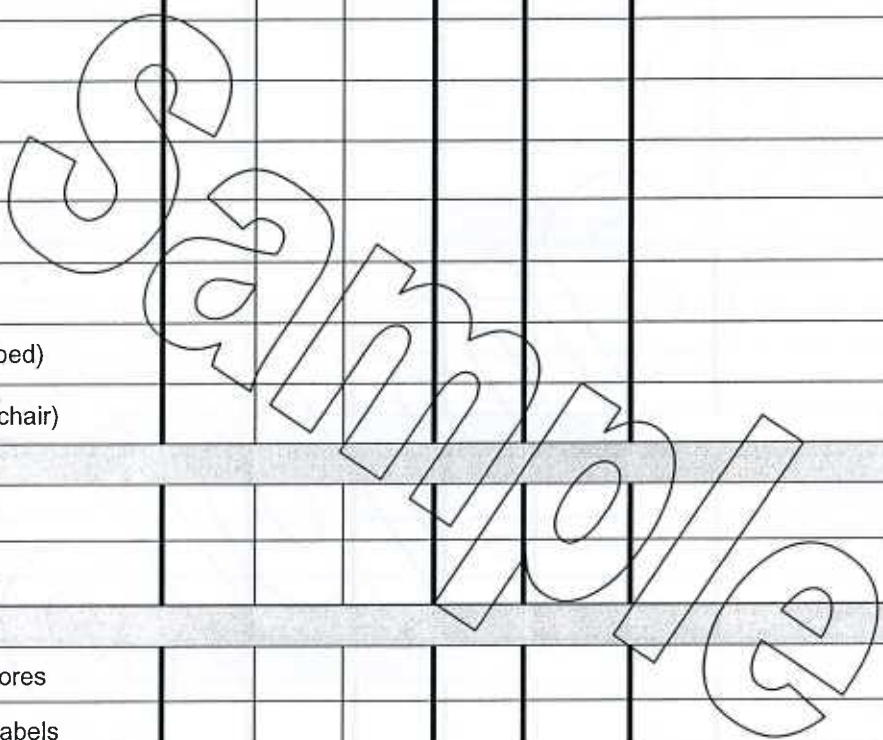
Comments:

<sup>1</sup> Periodic assistance - refers to the need for significant help for an activity some of the time as would be the case where a person required help due to the episodic nature of the impairment.

<sup>2</sup> Continuous assistance - refers to needing significant help most or all of the time for an activity.



C - DAILY LIVING ACTIVITIES						
Indicate the assistance required related to impairment(s) that directly restrict the client's ability to manage in the following areas. <u>Check all that apply.</u>	Independent	Periodic assistance <sup>3</sup> from another person	Continuous assistance <sup>4</sup> from another person or unable	Uses Assistive device (Explain)	Takes significantly longer than typical (describe how much longer)	Explain / Describe
1. Dressing						
2. Grooming						
3. Bathing						
4. Toileting						
5. Feeding self						
6. Regulate diet <sup>5</sup>						
7. Transfers (in/out of bed)						
6. Transfers (on/off of chair)						
<b>Basic Housekeeping</b>						
1. Laundry						
2. Basic Housekeeping						
<b>Shopping</b>						
1. Going to and from stores						
2. Reading prices and labels						
3. Making appropriate choices						
4. Paying for purchases						
5. Carrying purchases home						
Additional comments (including a description of the type and amount of assistance required and identification of any safety issues):						
_____						
_____						
_____						
_____						



<sup>3</sup> **Periodic assistance** - refers to the need for significant help for an activity some of the time as would be the case where a person required help due to the episodic nature of the impairment.

<sup>4</sup> **Continuous assistance** - refers to needing significant help most or all of the time for an activity.

<sup>5</sup> For example, issues related to eating disorders characterized by major disturbances in eating behaviour.

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C - DAILY LIVING ACTIVITIES (cont'd)						
Indicate the assistance required related to impairment(s) that directly restrict the client's ability to manage in the following areas. Check all that apply.	Independent	Periodic assistance from another person	Continuous assistance from another person or unable	Uses Assistive device (Explain)	Takes significantly longer than typical (describe how much longer)	Explain / Describe
1. Meal planning						
2. Food preparation						
3. Cooking						
4. Safe storage of food (ability, not environmental circumstances)						
<b>Paying Rent and Bills</b>						
1. Banking						
2. Budgeting						
3. Pay rent and bills						
<b>Medications</b>						
1. Filling/Refilling prescriptions						
2. Taking as directed						
3. Safe handling and storage						
<b>Transportation</b>						
1. Getting in and out of a vehicle						
2. Using public transit (where available)						
3. Using transit schedules and arranging transportation						
<b>Additional comments</b> (including a description of the type and amount of assistance required and identification of any safety issues):						

**C - DAILY LIVING ACTIVITIES (cont'd)**

**Social Functioning** Only complete this if the Client has an identified mental impairment, including brain injury.

Indicate the support/supervision required, as related to restrictions in the following areas:	Independent	Periodic Support/Supervision	Continuous Support/Supervision	Explain / Describe (include a description of the degree and duration of support/supervision required)
<b>Daily decision making, interacting, relating &amp; communicating with others</b>				
Appropriate social decisions (incl. avoiding situations dangerous to self or others, good social judgement)				
Able to develop and maintain relationships				
Interacts appropriately with others (e.g., understands and responds to social cues; problem solves in social context)				
Able to deal appropriately with unexpected demands				
Able to secure assistance from others				
Other (specify) _____				

**Describe how the mental impairment impacts the client's relationship with his/her:**

• **immediate social network (partner, family, friends)**

- good functioning - positive relationships: assertively contributes to these relationships
- marginal functioning - little significant participation/communication: relationships often minimal and fluctuate in quality
- very disrupted functioning - aggression or abuse: major withdrawn: often rejected by others

Comments:

• **extended social networks (neighbourhood contacts, acquaintances, storekeepers, public officials, etc.)**

- good functioning - positive interacts in community: often participates in activities with others
- marginal functioning - little more than minimal acts to fulfill basic needs
- very disrupted functioning - overly disruptive behaviour: major social isolation

Comments:

**If the client requires help, as indicated above, please describe the support/supervision required which would help to maintain him/her in the community.**

**Additional Comments (including identification of any safety issues):**

**D - ASSISTANCE PROVIDED FOR CLIENT**

**Assistance provided by other people**

The help required for daily living activities is provided by:

- Family
- Friends
- Health Authority Professionals (e.g., Nurse)
- Volunteers
- Community Service Agencies
- Other

Comments: \_\_\_\_\_

If help is required but there is none available, please describe what assistance would be necessary.

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**Assistance provided through the use of Assistive Devices**

What equipment or devices does the Client routinely use to help compensate for his/her impairment?

Check (✓) appropriate item(s):

- Cane
- Crutches
- Walker
- Manual Wheelchair
- Power Wheelchair
- Scooter
- Lifting device
- Hospital bed
- Prosthesis
- Splints
- Braces
- Feeding device
- Breathing device
- Commode
- Urillogical appliance
- Ostomy appliance
- Communication devices
- Interpretive services
- Toileting aids
- Bathing aids
- Other
- Specially designed adaptive housing

Please provide details on any equipment or devices used by the client:

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If equipment is required but is not currently being used, please describe the equipment or device that is needed:

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**Assistance provided by Assistance Animals**

Does the client have an Assistance Animal?  Yes  No

If yes, please specify either the nature of the assistance provided by the animal or the need:

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**E - ADDITIONAL INFORMATION**

Please provide any additional information that may be relevant to understanding the nature and extent of the client's impairment and its effect on daily living activities.

Lined area for providing additional information.

**F - APPROACHES AND INFORMATION SOURCES**

What approaches and information sources did you use to complete this form:

- office interview with client
- home assessment
- other assessments (specify) \_\_\_\_\_
- file/chart information (specify) \_\_\_\_\_
- family/friends/caregivers (specify) \_\_\_\_\_
- other professionals (specify) \_\_\_\_\_
- community services (specify) \_\_\_\_\_
- other (specify) \_\_\_\_\_

Lined area for providing additional information.

