Initial Assessment and Care and Treatment Request (Mental Health) (CF-MH-1)

For accidents that occur on or after **January 1, 2027**

Did you receive a referral? ☐ Yes ☐ No

If yes, indicate the full name of referring practitioner

Date of referral, as applicable *(dd-mm-yyyy)*

Part 1. Claimant Information

Last Name	First Name	Middle Name(s)
Mailing Address		City or Town
Province	Country	Postal Code	Email Address
Telephone Number	Date of Birth *(dd-mm-yyyy)*	Date of Accident *(dd-mm-yyyy)*

Employment Status (select all that apply)
☐ Employed ☐ Not Employed ☐ Student ☐ Retired

Is the claimant off work or off studies? (if applicable)
☐ Yes ☐ No ☐ Modified duties/hours

Policy Number (if known)	Claim Number (if known)

Insurance Company

Caregiving/Employment/Studies Status at the time of the accident (if applicable)

If involved in caregiving, are caregiving duties impacted by the injuries from this accident?
☐ Yes ☐ No ☐ N/A

If employed and/or engaged in studies, select all that apply and provide job title where applicable

Job title

Part 2. Clinical Assessment

Date of assessment (*dd-mm-yyyy*)

Symptoms and findings

Date of symptom onset (*dd-mm-yyyy*)

Describe functional limitations on daily living, caregiving duties, studies and work

Psychological/Psychometric testing

- Psychological assessment testing is not required
- Psychological assessment testing has not been completed
- Psychological assessment testing has been completed

Indicate tests and scores

Factors affecting test scores?

- No
- Yes

Explain

Has the claimant received a previous assessment or treatment for this condition?

- Yes
- No

If yes, describe

Date treatment started *(dd-mm-yyyy)*

Date treatment ended *(dd-mm-yyyy)*

Is treatment ongoing?

- Yes
- No

Name of Health Care Practitioner

Nature of treatment

The claimant presents with a risk for self-harm

- Yes
- No

If yes, describe the safety plan

Part 3. Barriers to Recovery

Barriers to recovery

☐ No barriers to recovery identified ☐ Barriers to recovery identified

Describe the barriers and how these may impact usual social functioning and recovery including employment, studies or caregiving, as relevant

Describe how these barriers will be addressed

Part 4. Diagnosis

Practitioners whose scope of practice does not include diagnosing mental health conditions should leave this part blank and complete the remainder of the form, as applicable.

Is there a psychological diagnosis?

☐ Yes ☐ No

Diagnosis (DSM-5)

Additional comments on the diagnosis

Part 5. Treatment Plan

Are psychological services required?

☐ Yes ☐ No

Session frequency

Treatment goals (including return to work, as applicable)

Recommended intervention(s) (e.g., treatment, modality and anticipated treatment length)

Are there other factors that may impact the claimant's ability to return to pre-accident functioning?

☐ No ☐ Yes

Additional comments

Part 6. Employment Activity (to be completed where applicable)

Fill this part if the claimant is currently off-work, on modified work duties, or is expected to be adjusting work status as a result of the injuries sustained from the accident.

	Functional limitation impacting employment	Relevant functional job demands	Treatment goal?
1.			Yes / No
2.			Yes / No
3.			Yes / No

Additional comments

Can resume regular duties	On date *(dd-mm-yyyy)*	Graduated hours, if required (enter duration)
Can return to work with modified duties	On date *(dd-mm-yyyy)*	Graduated hours, if required (enter duration)

Part 7. Treatment Plan Approval Request

Based on the treatment plan, I am requesting insurer approval for ▼ **sessions with an anticipated treatment end date of** ▼ ▼ ▼

Part 8. Health Care Practitioner Information

Full Name of Health Care Practitioner			
Profession			
Professional License Number, Registration Number, Association Membership Number as applicable			
Mailing Address			
City	Province	Country	Postal Code
Clinic Name	Administrative Contact's Full Name		

Telephone Number	Fax Number
Email	Preferred Contact Method
	Phone Email

Part 9. Health Care Practitioner Signature

I certify that the information provided is true and correct to the best of my knowledge.

Full Name of Health Care Practitioner (Please Print)	Date *(dd-mm-yyyy)*	Signature

Notice for Statutory Authority to Collect and Disclose Personal Information
The *Automobile Insurance Act* authorizes the collection and disclosure of the personal information required by this document.

Please consult your privacy officer, legal counsel, or the Office of the Information and Privacy Commissioner of Alberta regarding any questions about your obligations under applicable privacy legislation.

Any prescribed fee for this form is associated with the assessment and diagnosis performed by a health care practitioner whose scope of practice includes diagnosing mental health conditions. Health care practitioners whose scope of practice does not include diagnosing mental health conditions may complete applicable portions of the form; however, completion or submission of the form does not create entitlement to payment. Where prior insurer approval is required, approval must be obtained before submission of the request.