Program of Care Initial Assessment (CF-POC-1)

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

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

Was an ambulance required from the scene of the accident?
Yes | No

If yes, hospital name?

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. **If off work, please complete Part 8**

Job title

Part 2. Relevant Clinical History

Accident description

Previous diagnostic testing and treatment
Yes | No

If yes, describe

Please list the name of the Health Care Practitioner(s)

Relevant pre-existing conditions prior to accident?

Yes No

If yes, describe

Part 3. Clinical Assessment

Key subjective findings and symptoms

Key objective findings (for example, relevant range of motion, orthopedic testing, and/or neurological findings)

Functional Limitations

Describe functional limitations and indicate impact on daily living assistance (DLA), caregiving duties, studies, work and/or other

	DLA	Caregiving	Studies	Work	Other

Please provide additional details regarding the impact of the functional limitations below

Part 4. Barriers to Recovery

Barriers that may affect recovery (select all that apply)

Other (not in dropdown) _____

No barriers identified

Barriers to attending treatment

Yes No

If yes, specify

Part 5. Treatment interventions based on Care Pathway(s) (if treatment not required go to Part 9)

☐	Neck	Intervention(s) (select one or more)
☐	Shoulder	Intervention(s) (select one or more)
☐	Mid Back/Chest	Intervention(s) (select one or more)
☐	Low Back	Intervention(s) (select one or more)
☐	Concussion	Intervention(s) (select one or more)

Planned number of treatment visits in Phase 1

Planned number of treatment visits in Phase 2, if known

Additional treatment information, including addressing barriers to recovery

Part 6. Program of Care diagnosis(es)

Program of Care diagnosis(es) (select all that apply)

Part 7. Health Outcome Measure

Health Outcome Measure

WHODAS 2.0 (12-item)

Date administered *(dd-mm-yyyy)*

Initial Assessment Score

_____ / 48

Additional comments

Part 8. 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 on functional limitation impacting employment

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

Part 9. Assessment Conclusion

Program of Care — To begin on (*dd/mm/yyyy*)

Treatment not required

Additional comments

Part 10. Program of Care Health Care Practitioner Information

Full Name of Health Care Practitioner

Profession

Chiropractor | Nurse Practitioner | Physician | Physiotherapist

Professional License Number

Mailing Address

City	Province	Country	Postal Code

Clinic Name	Administrative Contact's Full Name
Telephone Number	Fax Number
Email	Preferred Contact Method Phone Email

I attest that I meet all the requirements to deliver the Care-First Program of Care, including education

Part 11. Program of Care Health Care Practitioner Signature

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

Full Name of Program of Care Health Care Practitioner (Please Print)	Date Report Completed and Signed (DD/MM/YYY)	Signature

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