

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)			Is the claimant off work or off studies? (if applicable)		
☐ Employed ☐ Not Employed ☐ Student ☐ Retired			☐ 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. If off work, please complete Part 6		
Job title		

Functional Limitations

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

Latest Progress assessment (Date_____)	Concluding assessment (Date_____)	DLA	Caregiving	Studies	Work	N/A
1. _____	_____	☐	☐	☐	☐	☐
2. _____	_____	☐	☐	☐	☐	☐
3. _____	_____	☐	☐	☐	☐	☐

☐ Functional limitations have resolved and no further treatment is required
Additional comments

Part 2. Health Care Practitioner Feedback

Diagnosis at initial assessment

Key subjective/physical examination findings at the last visit

Comments

Functional Goals (outcomes to be measured)

Goal 1: Progress towards goal

☐ Regressed ☐ Improved Minimally ☐ Improved Moderately ☐ Improved Significantly ☐ Plateaued ☐ Resolved
☐ Other _____

Comments on functional goal

Goal 2: Progress towards goal

☐ Regressed ☐ Improved Minimally ☐ Improved Moderately ☐ Improved Significantly ☐ Plateaued ☐ Resolved
☐ Other _____

Comments on functional goal

Goal 3: Progress towards goal

☐ Regressed ☐ Improved Minimally ☐ Improved Moderately ☐ Improved Significantly ☐ Plateaued ☐ Resolved
☐ Other _____

Comments on functional goal

Part 3. Treatment Summary

Total Number of Treatments

Date of First Visit (dd-mm-yyyy)

Date of Last Visit (dd-mm-yyyy)

Total Cancelled/Missed Visits

Part 4. Reason for Concluding Care and Treatment

Progress towards goals

☐ Full Recovery ☐ Partial Recovery ☐ Plateaued ☐ No Progress ☐ Transferred to another treatment provider
☐ Non Attendance ☐ Poor Compliance ☐ No Contact
☐ Other _____

Part 5. Recovery Status

Work restrictions?

☐ Yes ☐ No ☐ N/A If yes: ☐ Temporary Restriction(s) ☐ Permanent Restriction(s)

Comments

Has the claimant returned to a pre-accident level of activity outside of work?

☐ Yes ☐ No ☐ N/A

Comments

Did you refer the claimant to any Health Care Practitioner(s)?

☐ Yes ☐ No

If yes, who?

Comments (residual symptoms, signs, prognosis, details of exercise program, etc.)

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

Functional limitation impacting employment

Relevant functional job demands

Treatment goal?

2. ☐ Yes ☐ No

Functional limitation impacting employment

Relevant functional job demands

Treatment goal?

3. ☐ Yes ☐ No

Additional comments on functional limitation impacting employment

☐ 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. Health Care Practitioner Information

Full Name of Health Care Practitioner			
Profession			
Professional License or Registration 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	

Part 8. 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.