

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)		
<input type="checkbox"/> Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Retired			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified duties/hours		
Was an ambulance required from the scene of the accident?		If yes, hospital name?			
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Insurance Company			Claim Number (if known)		

Employment/Studies Status (if applicable)

If employed and/or engaged in studies, select all that apply and provide job title where applicable. **If off work, please complete Part 12**

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: Symptoms and Physical Findings

Key subjective findings and symptoms

Key physical 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

<input type="text"/>	DLA	Caregiving	Studies	Work	Other
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	DLA	Caregiving	Studies	Work	Other
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	DLA	Caregiving	Studies	Work	Other
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Program of Care

Part 5. Treatment interventions based on Care Pathway(s) (if treatment not required go to Part 8)



<input type="checkbox"/> Neck	Intervention(s) (select one or more)
<input type="checkbox"/> Shoulder	Intervention(s) (select one or more)
<input type="checkbox"/> Mid Back/Chest	Intervention(s) (select one or more)
<input type="checkbox"/> Low Back	Intervention(s) (select one or more)
<input type="checkbox"/> Concussion	Intervention(s) (select one or more)
Expected Frequency of Clinic Treatment Visits Per Week	
Phase 1 (0-6 weeks)	Phase 2 (7-12 weeks), if known
Additional treatment information	

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
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / 48
Additional comments	

Part 8. Assessment Conclusion

Based on this clinical assessment, the following is recommended

To begin on (dd/mm/yyyy)

Program of Care

Treatment not required

Additional comments

DRAFT

For additional injuries not covered by the Program of Care Care and Treatment Request for Insurer Approval

Part 9. Clinical Assessment: Symptoms and Physical Findings

Area of injury	Description
<input type="text"/>	<input type="text"/>
Symptoms	
<input type="text"/>	
Key subjective findings and symptoms	
<input type="text"/>	
Key physical findings (for example, relevant range of motion, orthopedic testing, and/or neurological findings)	
<input type="text"/>	

Functional Limitations

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

	DLA	Caregiving	Studies	Work	N/A
1. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Part 10. Diagnosis(es)

Diagnosis(es)
<input type="text"/>

Part 11. Treatment Plan

Investigations/diagnostics planned		
<input type="text"/>		
Treatment Modalities	Duration of treatment	Total number of visits
<input type="text"/>	<input type="text"/>	<input type="text"/>

Treatment Goals

Full functional recovery expected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated date (dd-mm-yyyy) <input type="text"/>
Resumption of daily living assistance (DLA) activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated date (dd-mm-yyyy) <input type="text"/>
Referrals for additional health care services? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, to whom <input type="text"/>

Part 12. 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. <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional comments <input type="text"/>		
<input type="checkbox"/> Can resume regular duties	On date (dd-mm-yyyy) <input type="text"/>	Graduated hours, if required (enter duration) <input type="text"/>
<input type="checkbox"/> Can return to work with modified duties	On date (dd-mm-yyyy) <input type="text"/>	Graduated hours, if required (enter duration) <input type="text"/>

Part 13. Treatment Plan Approval Request

Based on the treatment plan, I am requesting insurer approval for <input type="text"/> visits with an anticipated treatment end date of <input type="text"/>
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Part 14. Program of Care Health Care Practitioner Information

Full Name of Health Care Practitioner <input type="text"/>
Profession <input type="checkbox"/> Chiropractor <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist
Professional License Number <input type="text"/>

Mailing Address			
[Redacted]			
City	Province	Country	Postal Code
[Redacted]	[Redacted]	[Redacted]	[Redacted]
Clinic Name		Administrative Contact's Full Name	
[Redacted]		[Redacted]	
Telephone Number		Fax Number	
[Redacted]		[Redacted]	
Email		Preferred Contact Method	
[Redacted]		<input type="checkbox"/> Phone <input type="checkbox"/> Email	

I attest that I meet all the [requirements](#) to deliver the Care-First Program of Care, including education

Part 15. Program of Care Health Care Practitioner Signature

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

<input type="text"/>	<input type="text"/>	<input type="text"/>
Full Name of Program of Care Health Care Practitioner (Please Print)	Date (dd-mm-yyyy)	Signature

