

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		
Was an ambulance required from the scene of the accident?		If yes, hospital name?			
☐ Yes ☐ No					
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 5		
Job title		

Part 2. Clinical Assessment

Area of injury	Description
Symptoms	
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 and work

1.		DLA	Caregiving	Studies	Work	N/A
		☐	☐	☐	☐	☐
2.		DLA	Caregiving	Studies	Work	N/A
		☐	☐	☐	☐	☐
3.		DLA	Caregiving	Studies	Work	N/A
		☐	☐	☐	☐	☐

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

Part 3. Diagnosis(es)

Diagnosis(es)

Part 4. Treatment Plan

Investigations/diagnostics planned

Treatment Modalities

Duration of treatment

Frequency of visits

Total number of visits requested

Treatment Goals

Full functional recovery expected?

Estimated date (dd-mm-yyyy)

☐ Yes ☐ No

Resumption of daily living assistance (DLA) activities?

Estimated date (dd-mm-yyyy)

☐ Yes ☐ No

Referrals for additional health care services?

If yes, to whom

☐ Yes ☐ No

Functional Goals (outcomes to be measured)

Goal 1

Goal 2

Goal 3

Part 5. 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 6. Treatment Plan Approval Request

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

Part 7. Health Care Practitioner Information

Full Name of Health Care Practitioner			
Profession			
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	

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

This report is provided pursuant to section 58 of the *Automobile Insurance Act*, which requires an assessing or treating health care practitioner, upon request, to provide information reasonably required by the insurer related to the claimant's bodily injury for the administration of the claim.