Alberta

Initial Assessment and Care and Treatment Request (Physical) (CF-CT-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 5**

Job title

Part 2. Clinical Assessment

Area of injury	Description

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

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

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? ☐ Yes ☐ No	Estimated date (*dd-mm-yyyy*)
Resumption of daily living assistance (DLA) activities? ☐ Yes ☐ No	Estimated date (*dd-mm-yyyy*)
Referrals for additional health care services? ☐ Yes ☐ No	If yes, to whom

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 1.	Relevant functional job demands	Treatment goal? Yes / No
Functional limitation impacting employment 2.	Relevant functional job demands	Treatment goal? Yes / No
Functional limitation impacting employment 3.	Relevant functional job demands	Treatment goal? 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 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 Completed and Signed *(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.

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