Alberta

DRAFT- Care and Treatment Request (CF-CT-1A)

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

Did you receive a referral?	If yes, indicate the full name of referring health care practitioner	Date of referral, as applicable *(dd-mm-yyyy)*
☐ Yes ☐ No		

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)*

Insurance Company	Claim Number (if known)	Policy Number (if known)

Part 2. Clinical Assessment

Area of injury	Description

Symptoms

Key findings

Part 3. Treatment Plan

Treatment Plan

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	

Referrals for additional health care services?	If yes, to whom
☐ Yes ☐ No	

Part 4. Treatment Plan Approval Request

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

Part 5. Health Care Practitioner Information

Full Name of Health Care Practitioner			
Profession			
Professional License Number License Number, Registration Number, Association Membership Number as applicable			
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 6. 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

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