

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 3		
Job title		

Functional Limitations

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

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

Part 2. Response to Treatment

Number of treatments to date

Treatment provided

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. 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 4. 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 5. 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 information 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.

DRAFT