Care and Treatment Progress Form (Physical) (CF-CT-2)

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

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.							
Initial assessment (Date_____)	Progress assessment (Date_____)	DLA	Caregiving	Studies	Work	N/A
2.							
Initial assessment (Date_____)	Progress assessment (Date_____)	DLA	Caregiving	Studies	Work	N/A
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
2.			Yes / No
3.			Yes / No

Additional comments on functional limitation impacting employment

	On date *(dd-mm-yyyy)*	Graduated hours, if required (enter duration)
Can resume regular duties		
Can return to work with modified duties		

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 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.

Please consult your privacy officer, legal counsel, or the Office of the Information and Privacy Commissioner of Alberta regarding any questions about your obligations under applicable privacy legislation.