Alberta

DRAFT- Care and Treatment Concluding Report (Physical) (CF-CT-3)

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 6**

Job title

Functional Limitations

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

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

Functional limitations have resolved and no further treatment is required

Additional comments

Part 2. Health Care Practitioner Feedback

Diagnosis at initial assessment

Key subjective/physical examination findings at the last visit

Comments

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. Treatment Summary

Total Number of Treatments	Date of First Visit (*dd-mm-yyyy*)	Date of Last Visit (*dd-mm-yyyy*)	Total Cancelled/Missed Visits

Part 4. Reason for Concluding Care and Treatment or Need for Ongoing Treatment

Progress towards goals

☐ Full Recovery ☐ Partial Recovery ☐ Plateaued ☐ No Progress ☐ Transferred to another treatment site

☐ Non Attendance ☐ Poor Compliance ☐ No Contact

☐ Other_____

Part 5. Recovery Status

Work restrictions?

☐ Yes ☐ No ☐ N/A If yes: ☐ Temporary Restriction(s) ☐ Permanent Restriction(s)

Comments

Has the claimant returned to a pre-accident level of activity outside of work?

☐ Yes ☐ No ☐ N/A

Comments

Did you refer the claimant to any Health Care Practitioner(s)?

☐ Yes ☐ No

If yes, who?

Comments (residual symptoms, signs, prognosis, details of exercise program, etc.)

Part 6. 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

☐ 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 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.