Reporting period, as applicable (*dd-mm-yyyy* to *dd-mm-yyyy*)

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

Job title

Part 2. Clinical Assessment

Symptoms and findings

Describe current symptoms and changes since initial assessment and care and treatment request

Describe changes in impact on daily living assistance and functional limitations at this time

Describe changes in ability to complete caregiving, employment, or studies at this time, as applicable

Psychological/Psychometric testing

- Psychological assessment testing is not required at this stage
- No new psychological assessment testing completed
- Psychological assessment testing has been completed since last report

Indicate tests and scores

Has the claimant received additional assessment or treatment since the last report?

- Yes
- No

If yes, please describe

Date *(dd-mm-yyyy)*

Name of Health Care Practitioner

Nature of treatment

Part 3. Barriers to Recovery

Barriers to recovery

- No barriers to recovery identified
- Barriers to recovery identified

Describe current or ongoing barriers, changes since last report, and how these may impact recovery including employment, studies or caregiving

Describe how these barriers will be addressed

Part 4. Diagnosis and Treatment Plan

Has the diagnosis changed?

- Yes
- No

If yes, specify

Progress toward goals and recovery updates

The claimant presents with a risk for self-harm

- Yes
- No

If yes, describe any updates to the safety plan

Psychological services recommendation

- Continue as currently planned
- Modify and submit new request
- End and proceed to treatment onclusion

Explain

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

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

Part 5. 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 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

This informaiton 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.