

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)			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

Job title

Part 2. Clinical Assessment

Symptoms and findings
Describe current symptoms and changes since initial assessment
Describe changes in impact on daily living assistance and functional limitations during this reporting period
Describe changes in ability to complete caregiving, employment, or studies during this reporting period, 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

Part 3. Barriers to Recovery

Barriers to recovery

☐ No barriers to recovery identified ☐ Barriers to recovery identified

Describe current or ongoing barriers, changes within this reporting period, 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 treatment request ☐ End and proceed to treatment conclusion

Explain

Part 5. 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 6. 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 7. Health Care Practitioner Signature

I certify that the information provided is true and correct to the best of my knowledge.

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Full Name of Health Care Practitioner (Please Print)

Date (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