Care and Treatment Concluding Report (Mental Health) (CF-MH-3)

For accidents that occur on or after **January 1, 2027**

Date of treatment conclusion, as applicable *(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)
Policy Number (if known)		Claim Number (if known)
Insurance Company		

Employment Status: Employed | Not Employed | Student | Retired

Is the claimant off work or off studies? Yes | No | Modified duties/hours

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

Describe symptoms at conclusion

Describe functional status related to daily living assistance at conclusion

Describe ability to complete caregiving, employment, or studies at conclusion

Psychological/Psychometric testing

☐ Not required

☐ Psychological assessment testing completed at treatment conclusion

Indicate tests and scores

Part 3. Diagnosis and Treatment Outcome

Diagnosis at treatment conclusion (if applicable)

Treatment outcomes in relation to original functional treatment goals. Treatment goals

☐ Achieved ☐ Partially achieved ☐ Not achieved

Describe

The claimant presents with a risk for self-harm

☐ Yes ☐ No

If yes, describe ongoing safety considerations

Reason for concluding treatment

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

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The *Automobile Insurance Act* authorizes the collection and disclosure of the personal information required by this document.

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