

Date of treatment conclusion, as applicable (dd-mm-yyyy)

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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

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

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

DRAFT