Program of Care Phase 1 Form (CF-POC-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 3**

Job title

Part 2. Response to Treatment

Phase 1 Weeks 0-6

		Diagnosis	Response to Treatment
☐	Neck		
☐	Shoulder		
☐	Mid Back/Chest Wall		
☐	Low Back		
☐	Concussion		

Total number of treatment visits completed in Phase 1	Planned number of treatment visits in Phase 2

Functional Limitations

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

		DLA	Caregiving	Studies	Work	Other
1. Initial assessment (Date_____)	Phase 1 assessment (Date_____)					
2. Initial assessment (Date_____)	Phase 1 assessment (Date_____)					
3. Initial assessment (Date_____)	Phase 1 assessment (Date_____)					

Claimant self-rated recovery response (Claimant perception of injury recovery)

Part 3. 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 date *(dd-mm-yyyy)*	Graduated hours, if required (enter duration)
Can resume regular duties		
Can return to work with modified duties		

Part 4. Barriers to Recovery

Barriers that may affect recovery (select all that apply)

Other (not in dropdown) _____

No barriers identified

Barriers to attending treatment

Yes No

If yes, specify

Part 5. Phase 2 treatment interventions based on Care Pathway(s) (to be completed where applicable)

Phase 2 Weeks 7-12

Neck	Intervention(s) (select one or more)
Shoulder	Intervention(s) (select one or more)
Mid Back/Chest	Intervention(s) (select one or more)
Low Back	Intervention(s) (select one or more)
Concussion	Intervention(s) (select one or more)

Describe the Phase 2 functional and recovery goals

Expected Frequency of Clinic Treatment Visits Per Week Phase 2 (7-12 weeks)

Additional treatment information

Part 6. Health Outcome Measure at Phase 1

Health Outcome Measure

WHODAS 2.0 (12-item)

Date administered *(dd-mm-yyyy)*	Phase 1 Score	Score at Program of Care Initial Assessment
	_____ / 48	_____ / 48

Additional comments

Professional License Number

Part 7. Program of Care Health Care Practitioner Information

Full Name of Health Care Practitioner

Profession

☐ Chiropractor ☐ Nurse Practitioner ☐ Physician ☐ Physiotherapist

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

☐ **I attest that I meet all the requirements to deliver the Care-First Program of Care, including education**

Part 8. Program of Care Health Care Practitioner Signature

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

Full Name of Program of Care Health Care Practitioner (Please Print)	Date Report Completed and Signed (DD/MM/YYY)	Signature