Program of Care Phase 2 / Concluding Report (CF-POC-4)

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 2 Weeks 7-12

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

Total number of treatment visits completed in Phase 1	Total number of treatment visits completed in Phase 2	Total number of treatment visits completed in phase 1 and 2

Functional Limitations

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

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

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

Functional limitations have resolved and no further treatment is required

Additional comments

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. Health Outcome Measure at Phase 2

Health Outcome Measure

WHODAS 2.0 (12-item)

Date administered *(dd-mm-yyyy)*	Phase 2 Score
	_____ / 48

Phase 1 Score	Score at Program of Care Initial Assessment
_____ / 48	_____ / 48

Additional comments

Part 5. 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 6. 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

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.