


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)	
<input type="checkbox"/> Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Retired			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified duties/hours	
Was an ambulance required from the scene of the accident?		If yes, hospital name?		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Insurance Company		Claim Number (if known)		

Employment/Studies Status (if applicable)

If employed and/or engaged in studies, select all that apply and provide job title where applicable. **If off work, please complete Part 8** 

Job title

Part 2. Relevant Clinical History

Accident description

Previous diagnostic testing and treatment

Yes No

If yes, describe

Please list the name of the Health Care Practitioner(s)

Relevant pre-existing conditions prior to accident?

Yes No

If yes, describe

Part 3. Clinical Assessment: Symptoms and Physical Findings

Key subjective findings and symptoms

Key physical findings (for example, relevant range of motion, orthopedic testing, and/or neurological findings)

Functional Limitations

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

<input type="checkbox"/>	DLA	Caregiving	Studies	Work	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	DLA	Caregiving	Studies	Work	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	DLA	Caregiving	Studies	Work	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide additional details regarding the impact of the functional limitations below

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

If yes, specify

Yes No

Part 5. Treatment interventions based on Care Pathway(s) (if treatment not required go to Part 9) 

<input type="checkbox"/> Neck	Intervention(s) (select one or more)	<input type="text"/>
<input type="checkbox"/> Shoulder	Intervention(s) (select one or more)	<input type="text"/>
<input type="checkbox"/> Mid Back/Chest	Intervention(s) (select one or more)	<input type="text"/>
<input type="checkbox"/> Low Back	Intervention(s) (select one or more)	<input type="text"/>
<input type="checkbox"/> Concussion	Intervention(s) (select one or more)	<input type="text"/>
Expected Frequency of Clinic Treatment Visits Per Week		
Phase 1 (0-6 weeks)	Phase 2 (7-12 weeks), if known	<input type="text"/>
Additional treatment information, including addressing barriers to recovery		
<input type="text"/>		

Part 6. Program of Care diagnosis(es)

Program of Care diagnosis(es) (select all that apply)	
<input type="text"/>	

Part 7. Health Outcome Measure

Health Outcome Measure	
WHODAS 2.0 (12-item)	
Date administered (dd-mm-yyyy)	Initial Assessment Score
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / 48
Additional comments	
<input type="text"/>	

Part 8. 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. <input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Functional limitation impacting employment	Relevant functional job demands	Treatment goal?
2. <input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Functional limitation impacting employment	Relevant functional job demands	Treatment goal?
3. <input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional comments		
<input style="width: 100%; height: 40px;" type="text"/>		
<input type="checkbox"/> Can resume regular duties	On date (dd-mm-yyyy) <input style="width: 15%; height: 20px;" type="text"/> <input style="width: 15%; height: 20px;" type="text"/> <input style="width: 15%; height: 20px;" type="text"/>	Graduated hours, if required (enter duration) <input style="width: 80%;" type="text"/>
<input type="checkbox"/> Can return to work with modified duties	On date (dd-mm-yyyy) <input style="width: 15%; height: 20px;" type="text"/> <input style="width: 15%; height: 20px;" type="text"/> <input style="width: 15%; height: 20px;" type="text"/>	Graduated hours, if required (enter duration) <input style="width: 80%;" type="text"/>

Part 9. Assessment Conclusion

<input type="checkbox"/> Program of Care	To begin on (dd/mm/yyyy) <input style="width: 95%;" type="text"/>
<input type="checkbox"/> Treatment not required	
Additional comments	
<input style="width: 100%; height: 40px;" type="text"/>	

Part 10. Program of Care Health Care Practitioner Information

Full Name of Health Care Practitioner <input style="width: 100%; height: 30px;" type="text"/>			
Profession			
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Physician	<input type="checkbox"/> Physiotherapist
Professional License Number <input style="width: 100%; height: 30px;" type="text"/>			
Mailing Address <input style="width: 100%; height: 30px;" type="text"/>			
City <input style="width: 95%;" type="text"/>	Province <input style="width: 95%; height: 20px;" type="text"/>	Country <input style="width: 95%;" type="text"/>	Postal Code <input style="width: 95%;" type="text"/>

Clinic Name <input type="text"/>	Administrative Contact's Full Name <input type="text"/>
Telephone Number <input type="text"/>	Fax Number <input type="text"/>
Email <input type="text"/>	Preferred Contact Method <input type="checkbox"/> Phone <input type="checkbox"/> Email

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

Part 11. Program of Care Health Care Practitioner Signature

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

<input type="text"/>	<input type="text"/>	<input type="text"/>
Full Name of Program of Care Health Care Practitioner (Please Print)	Date (dd-mm-yyyy)	Signature

DRAFT