Alberta

Program of Care Phase 1 Report (XY-3)

This form is effective on **XX, 2027** for accidents that occur on or after **XX, 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

Was an ambulance required from the scene of the accident?
Yes | No

If yes, hospital name?

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 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		

Number of treatments

Total number of visits completed in phase 1

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)

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	If yes, specify
Yes / No	

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

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 *(dd-mm-yyyy)*	Signature