

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 3**

Job title

Part 2. Response to Treatment

Phase 2 Weeks 7-12

<input type="checkbox"/> Neck Care	Diagnosis	Response to Treatment
<input type="checkbox"/> Shoulder Care	Diagnosis	Response to Treatment
<input type="checkbox"/> Mid Back/Chest Wall	Diagnosis	Response to Treatment
<input type="checkbox"/> Low Back Care	Diagnosis	Response to Treatment
<input type="checkbox"/> Concussion Care	Diagnosis	Response to Treatment
Number of treatments	Total number of visits completed in phase 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. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initial assessment (Date _____)	Phase 1 assessment (Date _____)	DLA	Caregiving	Studies	Work	Other
2. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initial assessment (Date _____)	Phase 1 assessment (Date _____)	DLA	Caregiving	Studies	Work	Other
3. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Functional limitation impacting employment	Relevant functional job demands	Treatment goal?
2. _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Functional limitation impacting employment	Relevant functional job demands	Treatment goal?
3. _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional comments		

<input type="checkbox"/> Can resume regular duties	On date (dd-mm-yyyy)	Graduated hours, if required (enter duration)
	____ ▾ ____ ▾ ____ ▾	_____
<input type="checkbox"/> Can return to work with modified duties	On date (dd-mm-yyyy)	Graduated hours, if required (enter duration)
	____ ▾ ____ ▾ ____ ▾	_____

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 ____ / 48		Score at Program of Care Initial Assessment ____ / 48	
Additional comments			

Part 5. Program of Care Health Care Practitioner Information

Full Name of Health Care Practitioner			
Profession <input type="checkbox"/> Chiropractor <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician <input type="checkbox"/> 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 <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 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 (dd-mm-yyyy)	_____ Signature
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Part 7. Treatment Plan

Investigations/diagnostics planned		
Treatment Modalities	Duration of treatment	Total number of visits

Treatment Goals

Full functional recovery expected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated date (dd-mm-yyyy) <input style="width: 100%;" type="text"/>
Resumption of daily living assistance (DLA) activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated date (dd-mm-yyyy) <input style="width: 100%;" type="text"/>
Referrals for additional health care services? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, to whom <input style="width: 100%;" 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 1. <input style="width: 90%;" type="text"/>	Relevant functional job demands <input style="width: 90%;" type="text"/>	Treatment goal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Functional limitation impacting employment 2. <input style="width: 90%;" type="text"/>	Relevant functional job demands <input style="width: 90%;" type="text"/>	Treatment goal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Functional limitation impacting employment 3. <input style="width: 90%;" type="text"/>	Relevant functional job demands <input style="width: 90%;" type="text"/>	Treatment goal? <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%; text-align: center;"/> ▼ <input style="width: 15%; text-align: center;"/> ▼ <input style="width: 15%; text-align: center;"/> ▼	Graduated hours, if required (enter duration) <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Can return to work with modified duties	On date (dd-mm-yyyy) <input style="width: 15%; text-align: center;"/> ▼ <input style="width: 15%; text-align: center;"/> ▼ <input style="width: 15%; text-align: center;"/> ▼	Graduated hours, if required (enter duration) <input style="width: 100%;" type="text"/>

Part 9. Treatment Plan Approval Request

Based on the treatment plan, I am requesting insurer approval for visits with an anticipated treatment end date of

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