

Treatment Plan

Form AB-2

For accidents that occur on or after **October 1, 2004**

Send this form to the appropriate insurer:

Fax # (____) _____ - _____

To be completed by Claimant / Representative or a Primary Health Care Practitioner	
Insurance Company	
Policy Number	
Date of Accident: (DD-MM-YYYY)	

Part 1 – Claimant Information

Last Name	First Name	Date of Birth (DD/MM/YYYY)
Date of Accident (DD/MM/YYYY)		

Part 2 – Claimant's Authorized Representative

Last Name	First Name	Middle Name(s)
Address		
City, Town or County	Province	Postal Code
Relationship with Claimant <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other		
Telephone Number (Home) (Include area code)	Telephone Number (Work) (Include area code)	Fax Number (Include area code)

Part 3 – Therapy Status Report (To be completed by Primary Health Care Practitioner)

Diagnosis:	
Key Subjective/Physical Examination Findings:	
Sprain 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Strain 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> WAD 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other	ICD-10-CA Injury Code*
Is the claimant employed or engaged in training activities? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Not employed	
*ICD-10-CA injury codes are only required for Sprains, Strains and WAD injuries. It is recommended, not required, that ICD-10-CA injury codes be used for other injuries when practical.	

Functional Goals (outcomes to be measured):	
1. 2. 3.	
Comments	
Expected Number of Visits	Date of expected treatment discharge (DD/MM/YYYY)
Do you expect these visits to be sufficient to meet functional goals: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please provide details of expected further assessment and treatment:	Do you expect to reassess within three weeks due to alerting factors? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:

Part 4 – Treatment (To be completed with reference to the Diagnostic and Treatment Protocols Regulation)

Treatment Provided
Do you expect the claimant to return to normal and essential activities? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to determine If Yes, date expected?

Part 5 – Primary Health Care Practitioner Information

Name of Primary Health Care Practitioner	Profession <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physical Therapist		
Address			
City, Town or County	Province	Postal Code	
Administrative Contact Name		Facility Name	
Telephone Number (Include area code)		Fax Number (Include area code)	

Part 6 – Signature of Primary Health Care Practitioner

I certify that the information provided is true and correct to the best of my knowledge.	
Name (Please Print) _____	
Signature _____	Date _____

Part 7 – Choice in Following Diagnostic and Treatment Protocols

Please state your preference of treatment within or not within the Diagnostic and Treatment Protocols:

- I choose to be treated within the Diagnostic and Treatment Protocols as indicated on Form AB-1
- I choose **not to** be treated within the Diagnostic and Treatment Protocols

- I am the claimant
- I am the authorized representative of the claimant

I certify that the information provided is true and correct to the best of my knowledge. I confirm that I have consented to the collection, use and disclosure of my personal information for my treatment and care and determination of my eligibility for accident and/or disability income benefits as outline on Form **AB-1**.

Name (Please Print) _____

Signature _____ Date _____