Important Notice About Your Personal Information

Treatment Plan

Form AB-2

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

Print

Send this form to the appropriate insurer:	To be completed by Claimant / Representative or a Primary Health Care Practitioner	
Fax # (____)_____-_____	**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 ☐ Parent ☐ Guardian ☐ 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:

Diagnosis	ICD-10-CA Injury Code*
Sprain 1☐ 2☐ 3☐ Strain 1☐ 2☐ 3☐ WAD 1☐ 2☑ 3☐ 4☐ Other	

Is the claimant employed or engaged in training activities?

☑ Full Time ☐ Part Time ☐ Seasonal ☐ Self-employed ☐ Retired ☐ Student ☐ 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.

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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:	Do you expect to reassess within three weeks due to alerting factors?
☑ Yes ☐ No If No, please provide details of expected further assessment and treatment:	☐ Yes ☑ 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?

☑ Yes
☐ No
☐ Unable to determine

If Yes, date expected?

Part 5 – Primary Health Care Practitioner Information

Name of Primary Health Care Practitioner	Profession ☐ Medical Doctor ☐ Chiropractor ☑ 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_____

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