

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

☐ 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

Sprain
1 ☐ 2 ☐ 3 ☐

Strain
1 ☐ 2 ☐ 3 ☐

WAD
1 ☐ 2 ☐ 3 ☐ 4 ☐

Other

ICD-10-CA Injury Code*

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.

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