Treatment Plan (Form AB-2)

This form is effective on **November 20, 2004** for accidents that occur on or after **October 1, 2004**.

The personal information you provide in your Accident Claims Benefit Package (i.e. AB-1, AB-1A, AB-2, AB-4) is collected under the authority of the *Insurance Act*, Alberta's Automobile Insurance Accident Benefits Regulations, Diagnostic and Treatment Protocols Regulation and all applicable privacy legislation.

Your primary health care practitioner or dentist will need to collect personal information from you and from other health service providers and will need to use and disclose your personal information to provide you with appropriate diagnosis, treatment and care. Your insurance company and its agents will need to collect, use and disclose personal information from you, your primary health care practitioner, and other health service providers concerning the accident, your injuries, any pre-existing conditions that may impede your recovery process, the amount of treatment and care provided to you, and any assessments of your injuries and indications as to your treatment progress in order to facilitate contact with you, to determine your eligibility for accident and/or disability income benefits, and to administer your claim.

Under applicable privacy legislation, it is necessary to obtain your consent to authorize the sharing of your personal information as specified above. The legislation also regulates how primary health care practitioners, dentists, other health service providers, and insurance companies can use and disclose your information once they have it. Parts 5 and 6 of form AB-1 will ask for your consent or that of your agent. Refusal to provide your authorization and consent could result in an inability to provide you with the treatment and care you require (if not covered by Alberta Health Care Insurance) and may result in an inability for your insurance company to process your claim, in whole or in part. Your primary health care practitioner, dentist or other health service provider and insurance company will retain and rely on a copy of your consent for the period of time that your treatment and care is ongoing and your claim is active. You may revoke your consent at any time in writing to your primary health care practitioner or dentist and your insurer or any other person to whom you give consent, subject to continuing legal obligations. If you have any questions concerning the collection, use or disclosure of your personal information, please ask your primary health care practitioner, dentist, or your insurance claims representative or adjuster.

Part 1: Claimant Information

Last Name	First Name	Middle Name(s)

Mailing Address	City or Town

Province	Country	Postal Code	Email Address

Telephone Number (Home)	Telephone Number (Work)	Telephone Number (Cell)	Date of Birth *(dd-mm-yyyy)*	Gender
			- -	☐ Male ☐ Female

You can best be reached:

☐ at home/cell ☐ at work ☐ other (personal visit/email): _____

When is the best time to reach you (include days of the week)?	Date of Accident *(dd-mm-yyyy)*

Part 2: Claimant's Authorized Representative Information *(if applicable)*

Last Name	First Name	Middle Name(s)

Mailing Address

City or Town	Province	Country	Postal Code

Telephone Number (Home)	Telephone Number (Work)	Telephone Number (Cell)	Fax Number

Relationship with Claimant

☐ Parent ☐ Guardian ☐ other: _____

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

Diagnosis

Key Subjective/Physical Examination Findings or Functional Status Questionnaire Findings

Diagnosis ☐ Sprain ☐ 1 ☐ 2 ☐ 3 ☐ Strain ☐ 1 ☐ 2 ☐ 3 ☐ WAD ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other

ICD-10-CA Injury Code (ICD-10-CA injury codes are only required for Sprains, Strains and WAD injuries. Please see **Superintendent of Insurance Notice 07-2014** for further details. It is recommended, not required, that ICD-10-CA injury codes be used for other injuries when practical.

Is the claimant employed or engaged in training activities?

☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed ☐ Retired ☐ Student ☐ Not Employed ☐ Training/Apprenticeship

Functional Goals (outcomes to be measured)

Space has been provided for up to three goals.

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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.

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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.

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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 and the Superintendent of Insurance Bulletins 07-2014, 08-2014 and 09-2014, as appropriate)*

Treatment to be Provided
Do you expect the claimant to return to normal and essential activities? ☐ Yes ☐ No ☐ Unable to determine If yes, date expected *(dd-mm-yyyy)?* If no or unable to determine, please provide details.

Part 5: Primary Health Care Practitioner Information

Full Name of Primary Health Care Practitioner			Profession ☐ Medical Doctor ☐ Registered Practioner ☐ Chiropractor ☐ Physical Therapist
Mailing Address			
City or Town	Province	Country	Postal Code
Administrative Contact's Full Name	Facility Name		
Telephone Number	Fax Number		

Part 6: Primary Health Care Practitioner Signature

I certify that the information provided is true and correct to the best of my knowledge.

Full Name of Primary Health Care Practitioner (Please Print)	Date *(dd-mm-yyyy)*	Signature of Primary Health Care Practitioner

Part 7: Choice in Following Diagnostic and Treatment Protocols Regulation

Please state whether you choose to be treated within the Diagnostic and Treatment Protocols Regulation.

☐ I choose to be treated within the Diagnostic and Treatment Protocols Regulation as indicated on Form AB-1 (Notice of Loss and Proof of Claim).

☐ I choose **not to** be treated within the Diagnostic and Treatment Protocols Regulation.

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** (Notice of Loss and Proof of Claim).

☐ I am the claimant, OR ☐ I am the Authorized Representative of the claimant.

Name	Date *(dd-mm-yyyy)*	Signature

This Section to be Completed by Claimant / Authorized Representative or a Primary Health Care Practitioner		
Insurance Company		Policy Number
Date of Accident *(dd-mm-yyyy)*	Full Name of Claims Representative	Claim Number

Please forward this form to the Insurance Company.