You will need Acrobat Reader 6.0 or higher in order to complete this form online.

Important Notice About Your Personal Information

Concluding Report

Form AB-4

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 Initial Assessment *(DD/MM/YYYY)*		

Part 2 – Information of Primary Health Care Practitioner

Name of Professional		Profession
Address		
City, Town or County	Province	Postal Code
Scheduling Contact Name	Facility Name	
Telephone Number *(Include area code)*	Fax Number *(Include area code)*	

Part 3 – Assessment Status

Diagnosis at Initial Assessment:

Key Subjective and Physical Examination Findings at the last visit:

Functional Goals:	Progress towards goals
1.	☐ Regressed
2.	☐ Improved Minimally
3.	☐ Improved Significantly
	☐ Resolved
	☐ Plateaued
	☐ Other (please describe)

Part 4 – Treatment Summary

Total Number of Treatments	Date of First Visit *(DD/MM/YYYY)*	Date of Last Visit *(DD/MM/YYYY)*	Total Cancelled/Missed Visits

Part 5 – Reason for Discharge or need for ongoing Treatment

- ☐ Full Recovery
- ☐ Partial Recovery
- ☐ Plateaued
- ☐ No Progress
- ☐ Transferred to another treatment site
- ☐ Non-Attendance
- ☐ Poor Compliance
- ☐ No Contact
- ☐ Other (please describe)

Part 6 – Discharge Status

Is the claimant now working?

- ☐ Yes
- ☐ No
- ☐ Unknown

Are they employed or engaged in training activities?

- ☐ Full Time
- ☐ Part Time
- ☐ Seasonal
- ☐ Self-Employed
- ☐ Retired
- ☐ Student
- ☐ Not Employed

Work or Training Restrictions?

- ☐ None
- ☐ Yes

If Yes,

- ☐ Temporary Restriction
- ☐ Permanent Restriction

Has the claimant returned to a pre-accident level of activity outside work?

- ☐ Yes
- ☐ No

Did you refer the claimant to any other health care provider(s)? If yes, who?

- ☐ Yes
- ☐ No

Discharge comments (residual symptoms, signs, prognosis, details of exercise program, etc.):

Part 7 – Signature of Primary Health Care Practitioner

Name (Please Print) _____

Signature _____ Date_____

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