Return this form to the appropriate insurer:

Fax # (____)_____-_____

Treatment Plan
(Form NS-2)

For accidents that occur on or after April 1, 2013.

To be completed by the 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 (DDMMYYYY)
Date of Accident (DDMMYYYY)		

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		
Home Telephone Number (Include area code)	Work Telephone Number (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

Functional Goals (outcomes to be measured):
1.
2.
3.

Comments

Expected Number of Visits	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
Date of Expected Treatment Discharge (DD/MM/YYYY)	

Do you expect to reassess within three weeks due to alerting factors?
☐ Yes ☐ No If yes, please describe

* 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.

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 & 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 & Treatment Protocols:

☐ I choose to be treated within the Diagnostic & Treatment Protocols as indicated on Form NS-1

☐ I choose not to be treated within the Diagnostic & 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 outlined on Form NS-1.

Name (Please Print) _____

Signature _____ Date _____