# Mandatory

**Send this form to the appropriate insurer:**

**Fax # (____)_____-_____**

## Concluding Report
## (Form NS-4)

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

**This part to be completed by the claimant or their 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 Initial Assessment *(DDMMYYYY)* | | |

### Part 2 Information of Primary Health Care Practitioner

| Name of Professional (Please print) | | 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.<br>2.<br>3. | ☐ Regressed<br>☐ Improved minimally<br>☐ Improved significantly<br>☐ Resolved<br>☐ Plateaued<br>☐ Other (please describe) |

## Part 4 Treatment Summary

| Total Number of Treatments | Date of First Visit *(DDMMYY)* | Date of Last Visit *(DDMMYY)* | 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 _____

Signature _____ Date _____