

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

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

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 _____