

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: 1. 2. 3.	Progress towards goals ☐ Regressed ☐ Improved minimally ☐ Improved significantly ☐ Resolved ☐ Plateaued ☐ 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 ☐ Retired ☐ Part Time ☐ Student ☐ Seasonal ☐ Not Employed ☐ Self-Employed	Work or training restrictions? ☐ None If Yes: ☐ 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.): Not Reviewed		

Part 7 Signature of Primary Health Care Practitioner	Name _____	
	Signature _____	Date _____