Alberta Government

Concluding Report (Form AB-5)

Use this form for accidents that occur on or after **October 1, 2004.**

The personal information you provide in your Accident Claims Benefit Package (i.e. AB-1, AB-1A, AB-2, AB-4) is collected under the authority of the Insurance Act, Alberta's Automobile Insurance Accident Benefits Regulations, Diagnostic and Treatment Protocols Regulation and all applicable privacy legislation.

Your primary health care practitioner or dentist will need to collect personal information from you and from other health service providers and will need to use and disclose your personal information to provide you with appropriate diagnosis, treatment and care. Your insurance company and its agents will need to collect, use and disclose personal information from you, your primary health care practitioner, and other health service providers concerning the accident, your injuries, any pre-existing conditions that may impede your recovery proves, the amount of treatment and care provided to you, and any assessments of your injuries and indications as to your treatment progress in order to facilitate contact with you, to determine your eligibility for accident and/or disability income benefits, and to administer your claim.

Under applicable privacy legislation, it is necessary to obtain your consent to authorize the sharing of your personal information as specified above. The legislation also regulates how primary health care practitioners, dentists, other health service providers, and insurance companies can use and disclose your information once they have it. Parts 5 and 6 of form AB-1 will ask for your consent or that of your agent. Refusal to provide your authorization and consent could result in an inability top provide you with the treatment and care you require (if not covered by Alberta Health Care Insurance) and may result in the inability for your insurance company to process your claim, in whole or in part. Your primary health care practitioner, dentist or other health service provider and insurance company will retain and rely on a copy of your consent for the period of time that your treatment and care is ongoing and your claim is active. You may revoke your consent at any time in writing to your primary health care practitioner or dentist and your insurer or any other person to whom you give consent, subject to continuing legal obligations. If you have any questions concerning the collection, use or disclosure of your personal information, please ask your primary health care practitioner, dentist or your insurance claims representative or adjuster.

Referral to:

- ☐ **Primary Health Care Practitioner**
- ☐ **Injury Management Consultant**
- ☐ **Other** _____

Part 1 – Claimant Information

Last Name	First Name	Middle Name(s)
Mailing Address	City or Town	
Province	Country	Postal Code	Email Address
Telephone Number (Home)	Telephone Number (Work)	Telephone Number (Cell)	Date of Birth (DD/MM/YYYY)	Gender
You can best be reached: ☐ at home/cell ☐ at work ☐ other (personal visit/email): _____		
When is the best time to reach you (include days of the week)?	Date of Accident dd-mm-yyy	

Part 2 – Primary Health Care Practitioner Information (who is Referring the Claimant)

Full Name of Primary Health Care Practitioner	Profession		
Mailing Address			
City or Town	Province	Country	Postal Code
Administrative Contact Full Nam	Facility Name		
Telephone Number	Fax Number		

Part 3 – Professional to Whom Claimant is being Referred Information

Full Name of Primary Health Care Practitioner		Profession	
Mailing Address			
City or Town	Province	Country	Postal Code
Administrative Contact Full Nam	Facility Name		
Telephone Number	Fax Number		

Part 4 – Reason for the Referral

Opinion requested for: ☐ Definitive Diagnosis ☐ Treatment

Details

Part 5 – Details of the injury Investigations and Treatment to Date

Part 6– Information Enclosed

Enclosed is the following relevant information (e.g. consent form, reports of investigation including laboratory analysis, diagnostic imaging or other reports).

Part 7 – Primary Health Care Practitioner Signature

I certify that the information provided is true and correct to the best of my knowledge.

Full Name of Primary Health Care Practitioner (Please Print) Date - dd-mm-yyy Signature of Primary Heath Care Practitioner

This Section to be Completed by Claimant/Authorized Representative a Primary Health Care Practitioner

Insurance Company		Policy Number
Mailing Address	Full Name of Claims Representative	Claim Number

Please forward this form to the Insurance Company.