Alberta Government

Concluding Report (Form AB-4)

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.

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

Name of Primary Health Care Practitioner	Profession	☐ Medical Doctor	☐ Registered Practitioner
		☐ Chiropractor	☐ Physical Therapist

Mailing Address			
City or Town	**Province**	**Country**	**Postal Code**
Administrative Contact Full Name	**Facility Name**		
Telephone Number	**Fax Number**		

Part 3 – Primary Health Care Practitioner Feedback

Diagnosis at Initial Assessment , ,
Key Subjective/Physical Examination Findings at the last visit
Comments

Functional Goals (outcomes to be measured)

Space has been provided for up to three goals**.**

1.

Progress Towards Goals

☐ Regressed ☐ Improved Minimally ☐ Improved Moderately ☐ Improved Significantly ☐ Plateaued ☐ Resolved

☐ Other _____

2.

Progress Towards Goals

☐ Regressed ☐ Improved Minimally ☐ Improved Moderately ☐ Improved Significantly ☐ Plateaued ☐ Resolved

☐ Other _____

3.

Progress Towards Goals

☐ Regressed ☐ Improved Minimally ☐ Improved Moderately ☐ Improved Significantly ☐ Plateaued ☐ Resolved

☐ Other _____

Part 4 – Treatment Summary

Total Number of Treatments	Date of First Visit – dd-mm-yyyy	Date of Last Visit – dd-mm-yyyy

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, specify:

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 ☐ Training/Apprenticeship

Work or training restrictions? ☐ Yes ☐ No If Yes, ☐ Temporary Restriction ☐ Temporary Restriction
Comments

Has the claimant returned to a pre-accident level of activity outside of work? ☐ Yes ☐ No
Comments

Did you refer the claimant to any other health care provider(s)? ☐ Yes ☐ No
If yes, who

Discharge comments (residual symptoms, signs, prognosis, details of exercise program, etc)

Part 4 – 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.