



Treatment Plan

Return To ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6

Fax 1-877-686-4222



CLIENT INFORMATION			
CLAIM NUMBER	FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)

PRACTITIONER INFORMATION		
CLINIC NAME	VENDOR NUMBER	
PRACTITIONER FIRST NAME	PRACTITIONER LAST NAME	PRACTITIONER NUMBER

TREATMENT PLAN INFORMATION	
DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF TREATMENT PLAN (dd/mmm/yyyy)
PRACTITIONER/THERAPIST TYPE (select from list)	

What functional and symptom improvement has been made to date?

DESCRIBE THE CLIENT'S OBJECTIVE AND SUBJECTIVE IMPROVEMENTS.

What are the client's current functional limitations?

DESCRIBE THE CLIENT'S CURRENT RESTRICTIONS AS THEY RELATE TO PRE-INJURY FUNCTION.

What further progress is anticipated with the proposed additional treatment?

DESCRIBE THE FURTHER ANTICIPATED FUNCTIONAL IMPROVEMENTS BASED ON IDENTIFIED RESTRICTIONS.

What is the intended outcome or functional goal?

DESCRIBE THE MEASURABLE GOAL THE CLIENT IS WORKING TO ACHIEVE.

Are there any barriers that are delaying recovery? If so, please identify.

DESCRIBE ANY RELEVANT OBSTACLES THAT ARE CONTRIBUTING TO THE CLIENT'S CURRENT CONDITION AND RECOVERY.

Is the client currently missing work/school?

SELECT YES IF THE CUSTOMER IS ABSENT FROM EITHER WORK, SCHOOL OR ACTIVITIES OF DAILY LIVING THAT THEY WERE PARTICIPATING IN PRIOR TO THE INJURY.

Yes No

Additional comments

NUMBER OF NEW RECOMMENDED TREATMENTS TO DISCHARGE?

Expected discharge date

THE DATE YOU ANTICIPATE THAT THE CUSTOMER WILL HAVE COMPLETED TREATMENT (dd/mm/yyyy)

Your contact preference? Email Phone

Provide an email address or phone number in case we need to contact you

EMAIL

PHONE

This form must be completed in full. Incomplete Treatment Plans may result in delays.

I certify that:

When submitting a health care report, the information provided is accurate and complete based on all available information, treatments, and assessments performed.

Providing false or misleading information may result in the cancellation of your vendor number, and ICBC may seek financial restitution and/or take legal action.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information can be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.