

Pre-approved Framework Discharge & Status Report (OCF-24/198)

Use this form for accidents that occur on or after October 1, 2003

To the Health Professional/Facility:

Consent: It is the responsibility of the health professional/facility to ensure that the collection, use and disclosure of information submitted are authorized by a consent form. Health professionals/facilities should use the Ontario Claims Form 5 (OCF - 5) *Permission to Disclose Health Information* as a consent form, although additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

Use this form in accordance with the Pre-approved Framework Guidelines.

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

Part 1 Applicant Information	Date of Birth (YYYYMMDD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number	Extension
	Last Name			
	First Name		Middle Name	
	Address			
	City	Province	Postal Code	

Part 2 Insurance Company Information	Company Name		City or Town of Branch Office (if applicable)	
	Adjuster Last Name		Adjuster First Name	
	Adjuster Telephone	Extension	Adjuster Fax	
	Name of policy holder: Same as Applicant <input type="checkbox"/> OR:	Policy Holder Last Name	Policy Holder First Name	

Part 3 Patient Status	<input type="checkbox"/> Impairment resolved and patient discharged
	<input type="checkbox"/> Impairment improving
	<input type="checkbox"/> Impairment not resolving
	<input type="checkbox"/> Discharged because patient unreasonably failed to fully participate in the PAF
	<input type="checkbox"/> Discharged because patient withdrew consent to treatment

Part 4 Provider's Recommendation and PAF Extension Request	<input type="checkbox"/> Further or other treatment is being proposed through a Treatment Plan (OCF-18), and/or
	<input type="checkbox"/> Patient referred to another regulated health professional
	<input type="checkbox"/> Request for PAF extension: Number of treatment visits: _____ Total Cost: \$ _____ . _____

Part 5 Signature of Initiating Health Practitioner	Name of Initiating Health Practitioner (please print)	College Registration Number	You are a: <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist	
	Facility Name (if applicable)	AISI Facility Number (if applicable)		
	Address			
	City	Province		Postal Code
	Telephone Number	Extension		Fax Number
	Email Address			
	I certify that the information provided is true and correct. I understand that it is an offence under the <i>Insurance Act</i> to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal <i>Criminal Code</i> for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and detecting and preventing fraud.			
Name of Initiating Health Practitioner (please print)	Signature of Initiating Health Practitioner	Date (YYYYMMDD)		

Part 6 Approval	To the insurer: Please complete the following and return this page to the Health Practitioner.		
	<input type="checkbox"/> Extension Approved	<input type="checkbox"/> Extension Partially approved (explanation to follow or attached)	<input type="checkbox"/> Extension Not approved (explanation to follow or attached)
	Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)

**Part 7
Functional
Status**

Functional Status

- a) If employed at the time of the accident, has the applicant returned to his/her usual work activities? Not Employed Yes No
- b) Has the applicant returned to his/her usual non-work activities? Yes No
- c) Has the applicant recovered to his/her pre-accident level of overall function? Yes No
- d) Has the applicant returned to his/her care giving activities? Yes No

Complete the remainder of this form only if the answer to one or more questions in Part 7 was 'No'.

**Part 8
Factors
Related to
Applicant
Status**

(Required only if
any answer in
Part 7 is 'No')

Employment Status

If the applicant was employed at the time of the accident, please complete the following questions.

- a) If the applicant lost time from work has he/she returned to: Regular duties Modified duties/time
If modified duties / time, please describe:
- b) If not at work, has the employer been contacted to obtain work history and inquire about availability of modified duties / time? Yes No
If no, explain why:

Complicating Physical Factors

- a) Are there complicating physical factors that may predispose the applicant to slow recovery? Yes No
If yes, please specify:
- b) Has the applicant been referred to a health practitioner with respect to the identified physical factors? Yes No
 - i) Date of Referral (YYYYMMDD): _____/_____/_____
 - ii) Type of Health Practitioner: _____
- c) Is the applicant improving but slowly? Yes No
- d) Will the applicant benefit from continuation of specific therapies already being used? Yes No
If yes, what benefits are anticipated?

Applicant Non-Participation

- a) Was the applicant able and willing to engage in active therapies? Yes No
If no, explain why:
- b) Did the applicant miss more consecutive days and/or days of overall of treatment than allowed by a PAF Guideline without providing a reasonable explanation? Yes No
- c) Was there evidence of non-participation in home exercises without a reasonable explanation? Yes No
- d) Was there any other evidence of non-participation in the treatment? Yes No
If yes, please specify:

Barriers to Recovery (Please refer to the User Manual for completion of this section)

- a) What barriers to recovery have been identified for this applicant?
- b) When were they identified (YYYYMMDD)? _____/_____/_____
- c) Have you attempted to address these barriers to recovery in the treatment? Yes No
If yes, with what results?
- d) Is the applicant showing signs of emotional disturbance that require further consideration to determine if it results from the injury and require treatment? Yes No
- e) Has the applicant been referred to a health practitioner with respect to the identified factors? Yes No
 - i) Date of Referral (YYYYMMDD): _____/_____/_____
 - ii) Type of Health Practitioner: _____

Additional sheets attached