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

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

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

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.

Part 1 Applicant Information

Date Of Birth (YYYYMMDD)	Gender ❑ Male ❑ 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 ❑, OR:	Policy Holder Last Name	Policy Holder First Name

Part 3 Patient Status

- ❑ Impairment resolved and patient discharged
- ❑ Impairment improving
- ❑ Impairment not resolving
- ❑ Discharged because patient unreasonably failed to fully participate in the PAF
- ❑ Discharged because patient withdrew consent to treatment

Part 4 Provider's Recomanda-tion and PAF Extension Request

- ❑ Further or other treatment is being proposed through a Treatment Plan (OCF-18), and/or
- ❑ Patient referred to another regulated health professional
- ❑ 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	
Facility Name (if applicable)	AISI Facility Number (if applicable)	
Address		
City	Province	Postal Code
Telephone Number Extension	Fax Number	
Email Address		

You are a:
- ❑ Chiropractor
- ❑ Dentist
- ❑ Nurse Practitioner
- ❑ Occupational Therapist
- ❑ Optometrist
- ❑ Physician
- ❑ Physiotherapist
- ❑ Psychologist
- ❑ Speech-Language Pathologist

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act 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 Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

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.

❑ Extension Approved	❑ Extension Partially approved (explanation to follow or attached)	❑ 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