Insurer Identification (Name and Address)	**Ontario Automobile Insurance Medical or Psychological Report**	
	Insurer No.	Claim No.
Name of Policy Holder		Policy No. Claiming Under
Date of Accident Year Month Day	Date of First Visit Year Month Day	

Instructions

- This form must be completed and forwarded to the insurer within six weeks of your application for accident benefits, unless your insurer informs you that it is not needed.
- In the spaces provided above these instructions the claimant should fill in the name of the policy holder, policy number and the date information. The claimant should also complete section 1.
- The rest of the form should be completed and signed by your physician or psychologist.

1 Identity of Claimant

☐ Mr. ☐ Mrs. ☐ Ms. Last name	First name Mid. Init.	Date of Birth Year Month Day
	Area Code – Home Telephone No.	Area Code – Work Telephone No.

Street Address P.O. Box or Rural Route Apt.

City, Town, Village	Province or State	Country	Postal / Zip Code

Brief Description of Accident

2 Treating Practitioner

Dr. Last name	First name Mid. Init.	Area Code – Work Telephone No.
Street Address P.O. Box or Rural Route		Area Code – Fax No.

City, Town, Village	Province or State	Country	Postal / Zip Code

☐ Family Physician ☐ Other Physician (specify) ☐ Psychologist ☐ Other (specify)

3 Examination/Objective Findings

Date you most recently examined this patient Year Month Day

Physical and Mental Findings and Limitations (for medical use)

Other Limitations (psychological/psychiatric)

When did symptoms first appear?

Have you treated this patient for the same or similar condition prior to the accident (including pre-existing conditions which may be exacerbated by the current injury)? If yes, state when and describe briefly.

4 Investigations/Test Results

(Include Dates)

5 Diagnosis or Classification

Primary

Secondary

6 Treatment Plan

	Yes	No	Description
Investigations	☐	☐	
Medications	☐	☐	Description
Physiotherapy	☐	☐	Description
Consultation	☐	☐	Description

Other

Plan of Return Visits

☐ No further visits planned ☐ Further visits planned to Year Month Day

7 Duration of Disability

What, after discussion, is the estimate of when the claimant will be able to return to work or normal activities?

8 Signature of Physician or Psychologist

Signature	Date

The fee for completion of this form is not a health care benefit of the Ontario Ministry of Health. That fee, and the cost of any examinations not covered by the Health Insurance System, should be billed to the automobile insurer to whom this form is submitted.

Submission of a completed and signed form to the insurer constitutes a request for payment for its completion. No other invoice will be submitted.