Return this form to:

Minor Injury Treatment Discharge Report (OCF-24)

Use this form for accidents that occur on or after September 1, 2010

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

To the Health Practitioner/Facility Consent:
It is the responsibility of the health practitioner/facility to ensure that the collection, use and disclosure of information submitted are authorized by a consent form. Health practitioners /facilities should use the Ontario Claims Form 5 (OCF-5) *Permission to Disclose Health Information* as a consent form.

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 are subject to applicable privacy legislation.

This form is to be used in accordance with the treatment under the Minor Injury Guideline to discharge the insured person from the Minor Injury Guideline.

Part 1 Insured Person Information

Date Of Birth (YYYYMMDD)	Gender: ☐ Male ☐ Female	Telephone Number Extension
Last Name	First Name	

Part 2 Insurance Company Information

Company Name	Adjuster Telephone Extension
Adjuster Last Name	Adjuster First Name

Part 3 Health Practitioner Information and Signature

Name of Health Practitioner (please print)	College Registration Number
Facility Name (if applicable)	AISI Facility Number (if applicable)

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. Regulated sectors may be subject to an examination or inquiry about matters in connection with a licence and or unfair or deceptive act or practice. Non-compliance with applicable regulations may result in enforcement actions ranging from an administrative monetary penalty to prosecution under the Provincial Offences Act.

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. 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; **PREVENTING, DETECTING AND SUPPRESSING FRAUD.**

Signature of Health Practitioner	Date (YYYYMMDD)

Part 4 Insured Person's Discharge Status

Indicate the insured person's status at the time of discharge from the Minor Injury Guideline (check one).

☐ No additional intervention required.

☐ Additional intervention outside of the Minor Injury Guideline is required. If checked, specify one of following:

- ☐ I am submitting a Treatment and Assessment Plan (OCF-18) or the OCF-18 is waived by the insurer.
- ☐ I am referring to another health professional (please indicate name, address and specify the type of health professional, if known).

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☐ The insured person was discharged because he/she was non-compliant, was not attending sessions or voluntarily withdrew from treatment within the Minor Injury Guideline.

Part 5 Insured Person's Functional Status at Discharge

Indicate the insured person's functional status at the time of discharge from the Minor Injury Guideline (check all that apply)

☐ The insured person was employed at the time of the accident.

If checked, did the insured person lose time from work as a result of the accident? ☐ Yes ☐ No

If yes, is the insured person able to do his or her pre-accident work activities? ☐ Yes ☐ No

If yes, at what level? ☐ Full pre-accident ☐ Partial/modified

☐ The insured person was a care-giver at the time of the accident.

If checked, did the insured person lose time from care-giving as a result of the accident? ☐ Yes ☐ No

If yes, is the insured person returning to care-giving activities at discharge? ☐ Yes ☐ No

If yes, at what level? ☐ Full pre-accident ☐ Partial/modified

☐ The insured person was neither employed nor a care-giver at the time of the accident.

If checked, did the insured person have difficulty performing regular activities as a result of the accident? ☐ Yes ☐ No

If yes, is the insured person returning to regular activities at discharge? ☐ Yes ☐ No

If yes, at what level? ☐ Full pre-accident ☐ Partial/modified

☐ The insured person had difficulties performing housekeeping activities as a result of the accident.

If checked, did the insured person receive housekeeping assistance? ☐ Yes ☐ No

If yes, does the insured person still require housekeeping assistance following discharge? ☐ Yes ☐ No

☐ Has this been discussed with the insured person? ☐ Yes ☐ No

Provide additional information regarding the insured person's functional status, as necessary.

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