

Return this form to:

## Minor Injury Treatment Discharge Report (OCF-24)

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

|   |  |
|---|--|
| <b>Claim Number:</b>                    |  |
| <b>Policy Number:</b>                   |  |
| <b>Date of Accident:<br/>(YYYYMMDD)</b> |  |

### 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.**

|  |                          |  |                  |           |
|--|--------------------------|--|------------------|-----------|
| <b>Part 1<br/>Insured<br/>Person<br/>Information</b> | Date Of Birth (YYYYMMDD) | Gender:<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Telephone Number | Extension |
|  | Last Name                |  | First Name       |           |

|   |                    |                     |           |
|---|--------------------|---------------------|-----------|
| <b>Part 2<br/>Insurance<br/>Company<br/>Information</b> | Company Name       | Adjuster Telephone  | Extension |
|   | Adjuster Last Name | Adjuster First Name |           |

|   |   |                                      |
|---|---|--------------------------------------|
| <b>Part 3<br/>Health<br/>Practitioner<br/>Information<br/>and Signature</b> | 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. 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 analyzing 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. |                                      |
| Signature of Health Practitioner  |   | Date (YYYYMMDD)                      |

|   |   |
|---|---|
| <b>Part 4<br/>Insured<br/>Person's<br/>Discharge<br/>Status</b>   | <b>Indicate the insured person's status at the time of discharge from the Minor Injury Guideline (check one).</b>   |
|   | <input type="checkbox"/> No additional intervention required.<br><input type="checkbox"/> Additional intervention outside of the Minor Injury Guideline is required. If checked, specify one of following:<br><input type="checkbox"/> I am submitting a Treatment and Assessment Plan (OCF-18) or the OCF-18 is waived by the insurer.<br><input type="checkbox"/> I am referring to another health professional (please indicate name, address and specify the type of health professional, if known).<br><br>_____<br>_____<br>_____ |
| <input type="checkbox"/> 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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