

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL**.

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. _____

Part 1: Patient Authorization

Name (please print): _____ Date of birth: Year _____ Month _____ Day _____

Address: Street & Number _____

City _____ Province _____ Postal Code _____

Telephone Number (including area code): (_____) _____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life and administering the group benefits plan. **Medical and health information excludes genetic test results.**

I acknowledge that the personal information is needed by Canada Life for the purposes stated above. I acknowledge that my consent enables Canada Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Patient's Signature _____ Date _____

Part 2: Attending Physician's Statement

1. **Diagnosis** (including any complications). **Please attach a copy of all consultation, operative and pathology reports. Do not provide genetic test results.**

Date of cancer diagnosis: Year _____ Month _____ Day _____

Site of the tumor: _____

Type of tumor: _____

Histology and staging: _____

2. **History**

Date symptoms first appeared: Year _____ Month _____ Day _____

Has patient ever had the same or similar condition? Yes No

If yes, please specify diagnosis and dates of treatment. _____

Describe current symptoms: _____

First visit for these symptoms: Year _____ Month _____ Day _____

3. Current Height: _____ Current Weight: _____ Weight loss/gain to date: _____

4. In your opinion, when did the patient's condition first prevent him/her from working?

Year _____ Month _____ Day _____

5. **Treatment**

Date of first visit: Year _____ Month _____ Day _____

Date of latest visit: Year _____ Month _____ Day _____

Frequency of visits: Weekly Monthly Other

If other, please specify _____

Treatment: Include information on all treatments to date and future treatment plan, inclusive of:

Surgery: _____

Radiation: _____

Hormones: _____

Chemotherapy: _____

6. **Hospitalization** (if applicable for this illness or injury)

Date of in-patient admission: Year _____ Month _____ Day _____

Date of discharge: Year _____ Month _____ Day _____

Date of out-patient treatment: Year _____ Month _____ Day _____

Name of hospital: _____

7. Describe response to therapies to date: N/A partial Complete

Describe all comorbid conditions: _____

Describe any "post therapy" sequelae: _____

Prognosis: _____

8. Is the condition due to injury or sickness arising out of the patient's employment? Yes No

If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? Yes No

9. Please indicate your patient's current physical abilities:

Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

Light Duties: require frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.

Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

In your opinion, what is the earliest date your patient will be able to return to work?

Year _____ Month _____ Day _____

If the previous job could be modified, when could rehabilitation employment commence?

Year _____ Month _____ Day _____

10. Please provide the names of other physicians who have been/will be involved in assessing the medical problems; **and copies of any available consultation reports.**

11. We would appreciate any additional comments that would help us to better understand your patient and their condition.

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

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Patient's Signature _____ Date _____

Part 2: Attending Physician's Statement

1. **Diagnosis** (please provide copies of all relevant clinical notes, test results and consultation reports on file. **Do not provide genetic test results**)

Primary: _____

Secondary: _____

Date symptoms first appeared Year _____ Month _____ Day _____

Date of first visit Year _____ Month _____ Day _____

Date patient's condition first prevented them from working: Year _____ Month _____ Day _____

Date of latest visit: Year _____ Month _____ Day _____

Frequency of visits: Weekly Monthly Other _____

Date of hospital inpatient admission: Year _____ Month _____ Day _____

Date of discharge: Year _____ Month _____ Day _____

Date of hospital outpatient admission: Year _____ Month _____ Day _____

Name of hospital: _____

Subjective symptoms (including severity/frequency/duration): _____

2. **Findings**

Chest pain of cardiac origin Syncope Fatigue Dyspnea due to vascular congestion or hypoxia

Psychophysiologic Other (please specify): _____

BP readings over last 6 months (including dates) _____

Current height _____ Current weight _____ Weight loss/gain to date _____

Current status? Stable Improving Regressing

3. **Laboratory tests** (completed/scheduled) - please include copies of relevant test results.

EKG Year _____ Month _____ Day _____
 Echocardiogram Year _____ Month _____ Day _____
 Stress Thallium Test Year _____ Month _____ Day _____
 Pulmonary Function Test Year _____ Month _____ Day _____
 Blood Test Year _____ Month _____ Day _____
 X-rays Year _____ Month _____ Day _____
 Angiogram Year _____ Month _____ Day _____

4. **Treatment**

Medications (dose / frequency / date prescribed): _____

Other treatment (please describe): _____

Surgery date (past): Year _____ Month _____ Day _____ Type: _____

Surgery date (future): Year _____ Month _____ Day _____ Type: _____

Other treating physicians: _____

Is patient compliant with prescribed treatment? Yes No If No, please explain: _____

Has your patient been enrolled in a cardiac rehab program? Yes No

If yes, provide details: _____

5. **Restrictions and limitations**

Functional capacity: (Canadian Cardio-Vascular Society (CCS))

Level 1 (no limitation) Level 2 (mild impairment) Level 3 (moderate impairment) Level 4 (severe impairment)

	Weight	Frequency	Duration	What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation?
Lifting/Carrying	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			
Pushing/Pulling	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			How does this affect the patient's ability to perform activities of daily living?
Standing	_____ hours			
Walking	_____ blocks			
Driver's license revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

6. **Return to work plans:**

Prognosis for recovery: _____

Expected date patient will return to their own occupation: Year _____ Month _____ Day _____

If unknown, please indicate the next follow up date: Year _____ Month _____ Day _____

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work) _____

Assessment and treatment are complicated by: (please select and explain in the space provided below)

- Significant emotional or behavioral disorder such as depression, anxiety, etc.
 - Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations
 - Work-related issues (please describe if known) _____
 - Substance abuse _____
 - Other (please describe) _____
-

Rehabilitation:

Is patient a suitable candidate for medical rehabilitation services (ie. cardiopulmonary program, speech therapy, etc.)?

- Yes No

Is patient a suitable candidate for vocational rehabilitation? Yes No

If yes to either of the above, please specify: _____

7. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

Notice to Physician

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Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

Attending Physician's Statement

**MENTAL HEALTH
CONDITIONS**

Section A				Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT			
Plan Member/Employee Name (Last, First, Middle Initial)				Home Phone # (+ Area Code)		Cell Phone # (+ Area Code)	
Address (Street, City, Province, Postal Code)							
Employer's Name			Group Plan Number		Canada Life Employee Identification Number		Date of Birth (dd/mm/yyyy)
Date Last Worked (dd/mm/yyyy) _____		Date Returned to Work or Expected Return to Work Date, if known (dd/mm/yyyy) _____				Please provide your: Height: _____ Weight: _____	
<p>I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life Life and administering the group benefits plan. Medical and health information excludes genetic test results.</p> <p>I acknowledge that the personal information is needed by Canada Life Life for the purposes stated above. I acknowledge that my consent enables Canada Life Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s). This consent may be revoked by me at any time by sending a written instruction.</p> <p>I understand that I am responsible for any fees related to the completion of this form.</p> <p>I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.</p>							
Plan Member/Employee Signature _____				Date of Consent (dd/mm/yyyy) _____			
Section B		Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR					
I am the: Attending Physician <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____							
PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE							
1. Diagnosis							
Primary: _____ _____							
Secondary: _____ _____							
Is this condition related to: Occupational Illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> If so, date of event: (dd/mm/yyyy) _____							
Details: _____ _____							
Date of first visit to you pertaining to this condition (dd/mm/yyyy) _____				First date of work absence due to this condition: (dd/mm/yyyy) _____			
Has the patient been treated for this same or similar condition in the past? Yes <input type="checkbox"/> No <input type="checkbox"/>							
If yes, date: (dd/mm/yyyy) _____ By whom: _____							
Have you completed any other disability claim forms recently for this patient? Yes <input type="checkbox"/> No <input type="checkbox"/>							
If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.)							

2. Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity: _____

3. Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy / Vigour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration / Focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect / Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insight / Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Observations or comments supporting the above: _____

4. Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

- Workplace Issues Social / Family Issues Financial / Legal Problems
 Physical Condition Alcohol / Drug Abuse Medication Side Effects
 Pain Perception Coping Skills Personality / Motivation Other

Please describe:

Please describe the supports in place, or planned, to assist with these issues:

5. Investigations

Please attach copies of all relevant:

- test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
- consultation reports
- do not provide genetic test results

Are tests / investigations / consultations pending? Yes No Date report expected: (dd/mm/yyyy) _____

Does the patient have an appointment booked with an specialist(s) in the near future? Yes No

Name of Specialist _____ Specialty _____ Date of Appointment: (dd/mm/yyyy) _____

1. _____

2. _____

Reason for requesting the consultation: _____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes No Don't know

If yes, as of when? (dd/mm/yyyy) _____ Type of licence: _____

6. Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response

7. Hospitalization

Is/was the patient hospitalized? Yes No Is future hospitalization anticipated? Yes No

Date admitted (dd/mm/yyyy) _____ Date discharged (dd/mm/yyyy) _____ Institution Name _____

1. _____

2. _____

8. Treatment Details - Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		

9. Treatment Details - Concurrent Physiological Disorders, if known (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		

10. Overall Response to Treatment

Please describe the response to treatment to date: Complete Partial None Too soon to tell

Is the patient following the recommended treatment program? Yes No

Please explain: _____

Are there any plans to change or augment the current treatment program? Yes No

If so, please explain: _____

11. Prognosis and Recovery

What return-to-work goals have been discussed with the patient? Please explain: _____

Please provide the patient's prognosis for improvement: _____

Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis: _____

Notice to Physician

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Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

Patient consent

I authorize my healthcare provider to disclose my personal information, including medical and health information, to Canada Life for the purpose of investigating and assessing my claim(s), developing a rehabilitation plan to help me return to work, auditing the assessment of my claim(s), and administering the claim(s) and the group benefits plan. **Medical and health information excludes genetic test results.**

I acknowledge that my consent enables Canada Life to process my claim(s) and refusing to consent may result in delay or denial of my claim.

A photocopy or electronic copy of this consent form is as valid as the original.

This consent may be revoked by me at any time by sending a written instruction.

Your name (please print) _____ Date of birth _____

Your employer's name _____ Group plan number _____

Your signature _____ Date _____

Physician's statement

- Please print
- Please answer all questions in full
- Any charges for completion of this form is the patient's responsibility

Primary Diagnosis _____

Secondary Diagnosis _____

Has your patient ever had the same or a similar condition? Yes No

If yes, indicate when and provide details:

Date symptoms first presented Year _____ Month _____ Day _____

Date of first visit for this condition Year _____ Month _____ Day _____

Date the patient was first prevented from working Year _____ Month _____ Day _____

Please provide:

- A copy of your clinical notes, and
- Copies of imaging reports (X-ray, Ultrasound, CT, MRI) and other test results since symptom onset (do not include genetic test results). If tests are pending, indicate the date scheduled:

Indicate your patient's symptoms, frequency and severity:

Symptom	Frequency	Severity

Findings upon physical examination:

Current height _____ Current weight _____ Dominant hand: Left Right

Please indicate your patient's functional capabilities, noting only areas with impairment (if left blank, we will assume full function):

Endurance	Up to 4 hours continuously	2-4 hours continuously	1-2 hours continuously	up to 1 hour continuously	up to 20 mins	Unable/ Not at all	Expected duration of any restrictions
Sit							
Stand							
Walk							
Drive							

Activity		Constantly (85-100%)	Frequently (65-84%)	Regularly (34-64%)	Occasionally (33% or less)	Unable/ Not at all	Expected duration of any restrictions
Bend/Stoop							
Squat/Kneel							
Climb stairs							
Operate foot controls	Right						
	Left						
Push/Pull	Right						
	Left						
Reach							
Below shoulder	Right						
	Left						
Above shoulder	Right						
	Left						
Hand dexterity							
Gross manipulation (grip/ grasp)	Right						
	Left						
Fine manipulation (type/write/grip)	Right						
	Left						
Lift/Carry up to 10 lbs/4.5 kgs							
Lift/Carry up to 20 lbs/9.1 kgs							
Lift/Carry up to 50 lbs/22.7 kgs							

If there are restrictions not listed above, please indicate:

Describe the effect on activities of daily living (driving, shopping, household chores) and self-care (bathing, dressing, grooming, etc):

Have you provided advice regarding physical and psychological wellness (hurt vs harm, maintaining routines, etc.)? Yes No

Please explain:

What other activities have you recommended to promote recovery?

Has surgery been performed or planned? Year _____ Month _____ Day _____

Type of surgery: _____

Other treatment (cast, mobility aids, physio, orthotics, etc.):

Indicate the current medication(s), dosage(s), and when these were prescribed:

Medication	Current dosage	When current dosage was prescribed	Dosage changes

Is medication management optimal? Yes No If not, please elaborate:

What has been the response to treatment to date:

Upcoming changes to the treatment program:

Other treating physicians (please provide copies of the consultation reports):

Pending referrals: _____

Expected return to work date: _____ OR Unknown OR Not expected to return

Canada Life supports return to work efforts such as modified/alternate duties, part-time or transitional work, as being part of the recovery process. What return to work goals have been discussed/do you recommend?

Please outline any factors which may complicate recovery or create a barrier to return to work:

Please include any additional information you care to provide:

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Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

The patient is responsible for any fees related to the completion of this form.

Attending Physician's Statement

OTHER CONDITIONS

Section 1 Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)			
Employer's Name	Group Plan Number	Canada Life Employee Identification Number	Date of Birth (dd/mm/yyyy)
Date Last Worked (dd/mm/yyyy)		Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy)	
Please list your present medications: Name of Medication Dosage (mg) How Often?			Please provide your:
1. _____	_____	_____	Height: _____
2. _____	_____	_____	Weight: _____
3. _____	_____	_____	Dominant Hand: Left <input type="checkbox"/> Right <input type="checkbox"/>
4. _____	_____	_____	
5. _____	_____	_____	

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_____ Date of Consent (dd/mm/yyyy)

Plan Member/Employee Signature

Section 2 Attending Physician's Statement TO BE COMPLETED BY THE PHYSICIAN

I am the: Family Physician Consulting Specialist Other (please specify) _____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1. Diagnosis

Primary: _____

Secondary and/or Complications: _____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) _____

Is this condition due to: Occupational Illness/injury Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of event: (dd/mm/yyyy) _____	Auto Accident Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of event: (dd/mm/yyyy) _____
Have you completed any other disability claim forms recently for this patient? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____	
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____	First date of work absence due to condition: (dd/mm/yyyy) _____
Treatment	
e.g. Special Programs, Therapies, Medications: (if not noted by patient in Section 1) _____ _____ _____	
Frequency of Visits: Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/> (describe) _____ Date of last visit: (dd/mm/yyyy) _____	
Has the patient been treated for this same or similar condition in the past? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date: (dd/mm/yyyy) _____ Treatment provider: _____	
Is the patient following the recommended treatment program? Yes <input type="checkbox"/> No <input type="checkbox"/> Please elaborate: _____	
Response to Treatment	
Please describe the response to treatment to date: Complete <input type="checkbox"/> Partial <input type="checkbox"/> None <input type="checkbox"/> Too soon to tell <input type="checkbox"/>	
Are there any plans to change or augment the current treatment program? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please explain: _____	
Hospitalization	
Is/was the patient hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/> Is future hospitalization planned? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)
Institution Name	
1. _____	_____
2. _____	_____
3. _____	_____
If surgery was/will be performed, please provide date(s) and description of surgery(s):	
Date (dd/mm/yyyy)	Description
1. _____	_____
2. _____	_____

Investigations

➔ Please attach copies of all relevant:

- **test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**
- **do not provide genetic test results**

Are tests/investigations pending? Yes No

Date (dd/mm/yyyy)	Description
1. _____	_____
2. _____	_____

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes No

Name of Specialist	Specialty	Date (dd/mm/yyyy)
1. _____	_____	_____
2. _____	_____	_____

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? Improved No Change Retrogressed

Functional Abilities

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities:

Has any licence held by the patient been restricted or revoked as a result of this condition? Yes No

If yes, as of when? (dd/mm/yyyy) _____ Type of licence: _____

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals?

Yes No Please elaborate:

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

Notice to Physician

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