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

CLHIA ACCAP

Attending Physician's Statement - Short Term Disability Claim/Early Referral Services

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

Height	Weight	Date of Birth (dd/mm/yyyy)

Last Date Worked

(dd/mm/yyyy) ______________________________

Date Returned to Work or Expected Return to Work Date

(dd/mm/yyyy) ______________________________

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.

______________________________ ______________________________

Plan Member/Employee Signature Date of Consent (dd/mm/yyyy)

TO BE COMPLETED BY THE PHYSICIAN (or Nurse Practitioner Where Applicable)

STOP

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: ______________________________

Secondary and/or Complications: ______________________________

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) ______________ Vaginal ☐ C-Section ☐

Occupational Illness/injury Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy)

Auto Accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy)

Date of first visit to you pertaining to this condition:

(dd/mm/yyyy) ______________________________

First date of work absence due to condition:

(dd/mm/yyyy) ______________________________

Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy): ______________ Date of discharge (dd/mm/yyyy): ______________ Institution Name: ______________

If surgery was performed please provide date and description of surgery:

Date (dd/mm/yyyy): ______________ Description: ______________

Treatment (drug, dosage, physiotherapy, other):

____

Prognosis Please provide the prognosis for recovery:

____

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CLHIA ACCAP

Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date (dd/mm/yyyy): ____________________ Treatment Provider: ____________________

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

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other ____________________

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**

If consultation report is not attached, please indicate if the patient has or will be seen by a specialist for this condition.

Name of Specialist: ____________________ Specialty: ____________________ Date of Visit: ____________________

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

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Is the patient following the recommended treatment program? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)

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)	