canada life™

Cardiac Form

MORNEAU SHEPELL

Attending Physician's Statement

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU 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.**

Claims Administrator: The Canada Life Assurance Company (Canada Life)/Morneau Shepell PLAN NO.

Part 1: Patient Authorization

Name *(please print)*

Date of birth *(day, month, year)*

Address *(number, street, city, province, postal code)*

Telephone no. *(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/ Morneau Shepell for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life/ Morneau Shepell 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/ Morneau Shepell for the purposes stated above. I acknowledge that my consent enables Canada Life/ Morneau Shepell 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)

Part 2: Attending Physician's Statement

1 DIAGNOSIS OF PRESENT CONDITION (please provide copies of all relevant clinical notes, test results and consultation reports on file.)

Primary ______ Secondary ______

Onset of symptoms *(day, month, year)* ______ Date of first visit *(day, month, year)* ______

Date patient ceased to work because of incapacity *(day, month, year)* ______

Date of latest attendance: ____ / ____ / ____ (D M Y) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other ______

Date of hospital inpatient admission: ____ / ____ / ____ (D M Y) Date of discharge: ____ / ____ / ____ (D M Y)

Symptoms (severity / frequency / duration): ______

2 FINDINGS

☐ Chest pain of cardiac origin ☐ Syncope ☐ Fatigue

☐ Dyspnea due to vascular congestion or hypoxia ☐ Psychophysiologic

☐ Other (please specify):

Current blood pressure reading: ____ / ____ Height ______ Weight ______

Current status? ☐ Stable ☐ Improving ☐ Regressing

3 LABORATORY TESTS - Please include copies of relevant test results

Test		Dates *(day, month, year)*	
EKG	______	__ / __ / __	__ / __ / __
Echocardiogram	______	__ / __ / __	__ / __ / __
Stress Thallium Test	______	__ / __ / __	__ / __ / __
Pulmonary Function Test	______	__ / __ / __	__ / __ / __
Blood Test	______	__ / __ / __	__ / __ / __
X-rays	______	__ / __ / __	__ / __ / __
Other	______	__ / __ / __	__ / __ / __

4 TREATMENT

Medication (dose / frequency / date prescribed): ______

Other treatment (please describe): ______

Surgery date (past): ____ / ____ / ____ (D M Y) Type ______

Surgery date (future): ____ / ____ / ____ (D M Y) Type ______

Other treating physicians:

Is patient compliant with prescribed measures? ☐ Yes ☐ No If No, please explain: ______

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5 RESTRICTIONS AND LIMITATIONS

Functional Capacity: (Canadian Cardio-Vascular Society (CSS))
☐ Level 1 (no limitation) ☐ Level 2 (mild impairment)
☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

Weight	Frequency	Duration
Lifting / 1 - 10 lbs (0.5 - 4.5 kg)		
Carrying / 11 - 20 lbs (5.0 - 9.1 kg) 21 - 50 lbs (9.5 - 22.7 kg)		
Pushing / 1 - 10 lbs (0.5 - 4.5 kg)		
Pulling / 11 - 20 lbs (5.0 - 9.1 kg) 21 - 50 lbs (9.5 - 22.7 kg)		
Standing		
Walking		
Other		

What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation?

How does this affect the patient's ability to perform activities of daily living?

6 PROGNOSIS

Is there any restriction you would like to see placed on patient's return to work? ☐ Yes ☐ No

Comments: ______________________________

Estimated duration of restriction: ______________________________

Assessment and treatment are complicated by: (Please √ 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) ______________________________

☐ Other (please describe) ______________________________

Rehabilitation:

a) Is patient a suitable candidate for medical rehabilitation services? ☐ Yes ☐ No

b) Is patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No

c) If yes, 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?

Name of attending physician	Specialty	Telephone no. ( ) –
Address		
Signature		Date

Address: Canada Life/Morneau Shepell
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