canada life

General 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 HISTORY

a) Date symptoms first appeared or accident happened *(day, month, year)* _____

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

c) Has patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown If yes, state when and describe: _____

d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

e) Have Workers' Compensation / CSST forms been completed? ☐ Yes ☐ No ☐ Unknown

f) If diagnosis is pregnancy, give E.D.C. *(day, month, year)* _____

g) Names and specialties of other treating physicians:

h) Current Height _____ Current Weight _____

2 DIAGNOSIS OF PRESENT CONDITION

a) Primary _____

b) Additional conditions or complications _____

c) Subjective symptoms (including severity, frequency) _____

d) Findings (please enclose a copy of current X-rays, EKGs, laboratory data, blood pressure and any relevant clinical findings) _____

Please attach a copy of your clinical notes related to this period of disability and if available, please provide copies of all relevant consultation reports.

3 PHYSICAL CAPACITY (if applicable)

Describe functional capabilities of the following. Please specify continuous length of time or weight.

Sitting _____ Standing _____ Walking _____ Lifting _____ Carrying _____ Bending _____

4 TREATMENT DATES

a) Date of first visit for current condition *(day, month, year)* _____ b) Date of latest visit *(day, month, year)* _____

c) Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) _____

d) Date of hospital inpatient admission *(day, month, year)* _____ e) Date of discharge *(day, month, year)* _____

5 NATURE OF TREATMENT

a) Medications (including prescribed dosages) _____

b) Surgeries _____

c) Other _____

d) Is patient following recommended treatment program? ☐ Yes ☐ No (please elaborate) _____

6 CARDIAC (if applicable) Please forward copies of exercise stress test, angiogram, or other relevant documentation.

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

b) Last three Blood Pressure Readings (indicate dates)

____ / ____		____ / ____		____ / ____	
reading	Date *(day, month, year)*	reading	Date (day, month, year)	reading	Date *(day, month, year)*

7 PROGRESS

Has patient: ☐ Recovered ☐ Improved ☐ Not Improved ☐ Retrogressed

8 MENTAL / NERVOUS IMPAIRMENT (if applicable)

a) History

Precipitating Chronological Events _____

Work Issue Related to this illness? _____

Pre-morbid Personality? _____

Axis II Diagnosis _____

Relevant Current Dynamics _____

Changes in ADL habits _____

Familial Risk Factors _____

Progress with Treatment Plan _____

b) Are patient's symptoms due to drug or alcohol abuse? ☐ Yes ☐ No

c) If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility _____

d) Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state when _____

9 RESTRICTIONS

a) What are the patient's occupational limitations? _____

b) Estimated duration of limitations: _____

10 PROGNOSIS

a) Prognosis for medical recovery _____

b) Other factors affecting recovery _____

11 REHABILITATION

a) Is patient a suitable candidate for medical rehabilitation services? (e.g. cardiopulmonary program, speech therapy) ☐ Yes ☐ No

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

c) If yes, please specify: _____

12 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 *(please print)*	Specialty	Telephone no. *(including area code)*
		( ) –

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

Signature	Date *(day, month, year)*

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