canada life

Musculo-Skeletal

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 conultation reports on file.)

Primary _____ Secondary _____

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

Date of first visit for treatment or consultation *(day, month, year)* _____

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

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

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

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)

Other treating physicians: _____

2 SYMPTOMS

☐ Pain in the ☐ cervical ☐ thoracic ☐ lumbosacral area

☐ Stiffness or impaired range of motion

☐ Subjective weakness or incoordination

☐ Parasthesias or sensory disturbance in radicular or dermotomal pattern in the ☐ arm(s) ☐ leg(s) ☐ trunk

☐ Other (please specify): _____

3 PHYSICAL FINDINGS

☐ Distinct muscle spasm

☐ Loss or distortion of normal spine curves

☐ Neurological deficits: Power ☐ Yes ☐ No If yes, explain _____

Sensory Loss ☐ Yes ☐ No If yes, explain _____

Reflexes ☐ Yes ☐ No If yes, explain _____

☐ Range of Motion: Forward flexion _____ degrees Rotation _____ degrees

Lateral flexion _____ degrees SLR _____ degrees

☐ Specific reliable and reproducible signs (please list) _____

Limitations preventing retun to work: _____

4 TREATMENT

Medication (dose / frequency / date prescribed): _____

Physiotherapy (type, frequency, dates): _____

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

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

Other treatment: _____

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

5 RESULTS OF LABORATORY TESTS

		D M Y	D M Y
X-rays		____ / ____ / ____	____ / ____ / ____
CT Scan / MRI		____ / ____ / ____	____ / ____ / ____
EMG Studies		____ / ____ / ____	____ / ____ / ____
Other		____ / ____ / ____	____ / ____ / ____

PLEASE INCLUDE COPIES OF RELEVANT TEST RESULTS

6 RESTRICTIONS AND LIMITATIONS

Total Hours

Functional Capacity:
SITTING 8☐ 7☐ 6☐ 5☐ 4☐ 3☐ 2☐ 1☐ Other _____
STANDING 8☐ 7☐ 6☐ 5☐ 4☐ 3☐ 2☐ 1☐ Other _____
WALKING 8☐ 7☐ 6☐ 5☐ 4☐ 3☐ 2☐ 1☐ Other _____

What specific factors, if any, interfere with the patient's ability to sit, stand or walk? _____

What devices might improve the patient's ability to sit, stand or walk? _____

		Continuously	Frequently	Occasionally	Patient is able to:	Frequency/Duration
Lift / Carry	less than 10 lbs / 5 kg				**Drive**	
	more than 10 lbs / 5 kg				**Crouch**	
	more than 20 lbs / 10 kg				**Balance**	
	more than 50 lbs / 25 kg				**Bend / Stoop**	
Push / Pull	less than 10 lbs / 5 kg				**Twist**	
	more than 10 lbs / 5 kg				**Kneel / Squat**	
	more than 20 lbs / 10 kg				**Climb Stairs**	
	more than 50 lbs / 25 kg				**Reach at shoulder level**	
					Reach above shoulders	
					Reach below shoulders	

7 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: _____

8 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)*

Address:
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Fax: 1.877.562.9126
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