canada life™

Rheumatology 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 and consultation reports.)

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: ______

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 (please describe severity, frequecy and duration) ______

2 RHEUMATOID ARTHRITIS

List joints involved: ______

Is objective evidence of synovitis and joint deformity present? ☐ Yes ☐ No

Is contracture, ankylosis or impaired range of motion present? ☐ Yes ☐ No

If yes, describe: ______

Laboratory Findings

☐ Positive synovial fluid findings ______ ☐ A.N.A. ______ Normal ______

☐ Rheumatoid factor titer ______ Normal ______

☐ Histologic change from biopsy ______ ☐ Sedimentation rate ______ Normal ______

☐ Other (please specify): ______

Are X-ray findings characteristic of, or compatible with Rheumatoid Arthritis? ☐ Yes ☐ No

Results of surgical treatment: ______

3 OSTEOARTHRITIS

List joints involved: ______

Is joint deformity and/or limitation of motion present? ☐ Yes ☐ No If yes, describe: ______

Are X-ray findings characteristic of degenerative joint disease? ☐ Yes ☐ No

Results of medical or surgical treatment: ______

4 OTHER RHEUMATIC DISEASE

☐ Reiter's Syndrome ☐ Ankylosing Spondylitis

☐ Connective Tissue Disorders ______ ☐ Other ______

Do X-ray findings confirm diagnosis? ☐ Yes ☐ No If yes, describe: ______

PLEASE PROVIDE COPIES OF RELEVANT TEST RESULTS

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5 FUNCTIONAL CAPACITY

Patient is able to:	FREQUENCY	DURATION
Sit		
Stand		
Walk		
Drive a Car		
Bend / Twist		
Squat / Kneel / Crouch		
Climb Stairs		
Reach Above Shoulder Level		
Reach Below Shoulder Level		
Lift up to 10 lbs / 5 kg		
20 lbs / 10 kg		
50 lbs / 25 kg		

Dominant Hand *(circle one)*: **LEFT** **RIGHT**

Can patient use his/her hands and fingers for gross or fine movements? (please specify)

Is patient independent for activities of daily living? (e.g., bathing, dressing, toileting, transferring, mobility, etc.)

List any assistive devices or aids that would improve the patient's ability to use his/her hands or to increase ability to sit, stand or walk:

What reasonable job or work site modifications could the employer make to assist the patient in returning to work?

6 TREATMENT

Medication (dose / frequency / date prescribed): ______

Other (please describe type, frequency, dates): ______

Is surgery anticipated? ☐ Yes ☐ No If yes, when? ____ D /____ M /____ Y Type: ______

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

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

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)*

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