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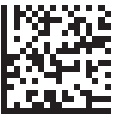


# ATTENDING PHYSICIAN'S DISABILITY BENEFITS STATEMENT

(or at the insurer's option such other benefits as the insurer may wish to state)

## PART 1: PATIENT AUTHORIZATION To be completed by the owner/insured

Name (first and last)

| Policy Number | Date of Birth | Phone number (include area code) |
|---|---|---|
| | | |

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

Email

I hereby authorize the release to my insurer of any information requested in respect of this claim.

Patient's Signature ______________________ Date ______________________
(day, month, year)

## PART 2: ATTENDING PHYSICIAN'S STATEMENT

**1. History**

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

b) Date patient ceased work because of current condition (day, month, year)

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

d) Has patient ever had same or similar condition
☐ No ☐ Unknown ☐ Yes, state and describe

e) Is condition considered chronic
☐ No ☐ Yes, what precipitated absence from work

f) Names of other treating physicians or health care providers

**2. Diagnosis** (including any complication)

a) Primary

b) Additional conditions or complications which might affect duration of absence from work

c) Subjective symptoms

d) Objective signs (Please attach copies of current x-rays, EKGs, laboratory data and any relevant clinical findings that support your diagnosis)

**3. Physical Impairment**

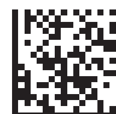
What physical limitations affect the claimant's ability to work (eg. limitations with respect to lifting, carrying, bending, walking, standing)

**4. Mental/Nervous Impairment** (if applicable)

a) How does patient's mental or nervous impairment affect ability to work

d) Has there been psychiatric referral
☐ Yes ☐ No

e) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof
☐ Yes ☐ No



# ATTENDING PHYSICIAN'S DISABILITY BENEFITS STATEMENT

(or at the insurer's option such other benefits as the insurer may wish to state)

## PART 2: ATTENDING PHYSICIAN'S STATEMENT (continued)

**5. Cardiac** (if applicable)

a) Functional capacity (American Heart Association)

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

**Please forward results of exercise stress tests, angiogram or other relevant documentation.**

b) Blood pressure (last visit)

| Systolic | Diastolic |
|---|---|
| | |

**6. Treatment** (including any complication)

a) Date of first visit (day, month, year)

b) Date of latest visit (day, month, year)

c) Frequency of visits

☐ Weekly ☐ Monthly ☐ Other (specify)

d) Nature of treatment (including surgery, physiotherapy and medications prescribed, if any)

d) To your knowledge is patient following recommended treatment program

☐ Yes ☐ No, please comment

**7. Progress**

Has patient ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

**8. Prognosis**

| | **Regular Occupation** | **Any Other Occupation** |
|---|---|---|
| a) Does disability prevent patient from performing? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) If "yes", please indicate when you expect patient will recover sufficiently to perform duties of: | ☐ 1-3 months<br>☐ 3-6 months<br>☐ others, please specify<br>______<br>☐ Never<br>______<br>Month Day Year | ☐ 1-3 months<br>☐ 3-6 months<br>☐ others, please specify<br>______<br>☐ Never<br>______<br>Month Day Year |

**9. Rehabilitation**

a) Is patient a suitable candidate for further medical rehabilitation service (ie. cardiopulmonary program, speech therapy, etc.)

☐ Yes ☐ No

b) Would vocational counselling and/or retraining be recommended

☐ Yes ☐ No

c) Is patient suitable for trial employment

☐ No ☐ Yes, state date, ______

Day, Month, Year

**10. Remarks** - Please provide comments and further details which you feel would be helpful

| Name of attending physician (please print) | Specialty | Telephone No. |
|---|---|---|
| | | |

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

| Signature | Date (day, month, year) |
|---|---|
| | |

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