canada life™

INITIAL ATTENDING PHYSICIAN'S STATEMENT

Cancer Form

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE 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.

PLAN NO. ____________________

Part 1: Patient Authorization

Name (please print): ______________________ Date of birth: Year ________ Month ________ Day ________

Address: Street & Number ______________________________

City ______________________ Province ______________ Postal Code ______________

Telephone Number (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 for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life 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 for the purposes stated above. I acknowledge that my consent enables Canada Life 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.

Patient's Signature ______________________________ Date ______________

Part 2: Attending Physician's Statement

1. **Diagnosis** (including any complications). **Please attach a copy of all consultation, operative and pathology reports. Do not provide genetic test results.**

   Date of cancer diagnosis: Year ________ Month ________ Day ________

   Site of the tumor: ______________________________

   Type of tumor: ______________________________

   Histology and staging: ______________________________

2. **History**

   Date symptoms first appeared: Year ________ Month ________ Day ________

   Has patient ever had the same or similar condition? ☐ Yes ☐ No

   If yes, please specify diagnosis and dates of treatment. ______________________________

   ____

   Describe current symptoms: ______________________________

   First visit for these symptoms: Year ________ Month ________ Day ________

3. Current Height: ______________ Current Weight: ______________ Weight loss/gain to date: ______________

4. In your opinion, when did the patient's condition first prevent him/her from working?

   Year ________ Month ________ Day ________

5. **Treatment**

   Date of first visit: Year ________ Month ________ Day ________

   Date of latest visit: Year ________ Month ________ Day ________

   Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

   If other, please specify ______________________________

   Treatment: Include information on all treatments to date and future treatment plan, inclusive of:

   Surgery: ______________________________

   Radiation: ______________________________

   Hormones: ______________________________

   Chemotherapy: ______________________________

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

6. **Hospitalization** (if applicable for this illness or injury)

Date of in-patient admission: Year __________ Month ______________ Day ________

Date of discharge: Year __________ Month ______________ Day ________

Date of out-patient treatment: Year __________ Month ______________ Day ________

Name of hospital: ____

7. Describe response to therapies to date: ☐ N/A ☐ partial ☐ Complete

Describe all comorbid conditions: ____

Describe any “post therapy”sequelae: ____

Prognosis: ____

8. Is the condition due to injury or sickness arising out of the patient’s employment? ☐ Yes ☐ No

If yes, has your office filed a claim for this condition with the Workers’ Compensation Board on behalf of your patient? ☐ Yes ☐ No

9. Please indicate your patient’s current physical abilities:

☐ Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

☐ Light Duties: require frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

☐ Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.

☐ Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

In your opinion, what is the earliest date your patient will be able to return to work?

Year __________ Month ______________ Day ________

If the previous job could be modified, when could rehabilitation employment commence?

Year __________ Month ______________ Day ________

10. Please provide the names of other physicians who have been/will be involved in assessing the medical problems; **and copies of any available consultation reports.**

____

____

11. We would appreciate any additional comments that would help us to better understand your patient and their condition.

____

____

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician’s Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

INITIAL ATTENDING PHYSICIAN'S STATEMENT

Cardiac Form

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE 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.

PLAN NO. ___________________

Part 1: Patient Authorization

Name (please print): ________________________ Date of birth: Year _________ Month ___________ Day _________

Address: Street & Number ____

City ____________________ Province ______________ Postal Code ______________

Telephone Number (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 Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life Life 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 Life for the purposes stated above. I acknowledge that my consent enables Canada Life Life 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.

Patient's Signature ______________________________________ Date ____________________

Part 2: Attending Physician's Statement

1. **Diagnosis** (please provide copies of all relevant clinical notes, test results and consultation reports on file. **Do not provide genetic test results**)

   Primary: ____

   Secondary: ____

   Date symptoms first appeared Year ___________ Month ___________ Day ___________

   Date of first visit Year ___________ Month ___________ Day ___________

   Date patient's condition first prevented them from working: Year ___________ Month ___________ Day ___________

   Date of latest visit: Year ___________ Month ___________ Day ___________

   Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other ______________________________

   Date of hospital inpatient admission: Year ___________ Month ___________ Day ___________

   Date of discharge: Year ___________ Month ___________ Day ___________

   Date of hospital outpatient admission: Year ___________ Month ___________ Day ___________

   Name of hospital: ____

   Subjective symptoms (including severity/frequency/duration): ______________________________

2. **Findings**

   ☐ Chest pain of cardiac origin ☐ Syncope ☐ Fatigue ☐ Dyspnea due to vascular congestion or hypoxia

   ☐ Psychophysiologic ☐ Other (please specify): ______________________________

   BP readings over last 6 months (including dates) ______________________________

   Current height _______________ Current weight _____________ Weight loss/gain to date _______________

   Current status? ☐ Stable ☐ Improving ☐ Regressing

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

3. **Laboratory tests** (completed/scheduled) - please include copies of relevant test results.

EKG Year ___________ Month ______________ Day ________

Echocardiogram Year ___________ Month ______________ Day ________

Stress Thallium Test Year ___________ Month ______________ Day ________

Pulmonary Function Test Year ___________ Month ______________ Day ________

Blood Test Year ___________ Month ______________ Day ________

X-rays Year ___________ Month ______________ Day ________

Angiogram Year ___________ Month ______________ Day ________

4. **Treatment**

Medications (dose / frequency / date prescribed): ________________________________

Other treatment (please describe): ________________________________

Surgery date (past): Year ___________ Month ______________ Day ________ Type: ________________

Surgery date (future): Year ___________ Month ______________ Day ________ Type: ________________

Other treating physicians: ________________________________

Is patient compliant with prescribed treatment? ☐ Yes ☐ No If No, please explain: ________________

____

Has your patient been enrolled in a cardiac rehab program? ☐ Yes ☐ No

If yes, provide details: ________________________________

____

5. **Restrictions and limitations**

Functional capacity: (Canadian Cardio-Vascular Society (CCS))

☐ Level 1 (no limitation) ☐ Level 2 (mild impairment) ☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

	Weight	Frequency	Duration	What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation?
Lifting/Carrying	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			
Pushing/Pulling	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			How does this affect the patient's ability to perform activities of daily living?
Standing ___________ hours Walking ___________ blocks Driver's license revoked? ☐ Yes ☐ No				

6. **Return to work plans:**

Prognosis for recovery: ________________________________

Expected date patient will return to their own occupation: Year ___________ Month ______________ Day ________

If unknown, please indicate the next follow up date: Year ___________ Month ______________ Day ________

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work) ________________________________

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

Assessment and treatment are complicated by: (please select 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) ______

☐ Substance abuse ______

☐ Other (please describe) ______

______

Rehabilitation:

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

☐ Yes ☐ No

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

If yes to either of the above, 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?

______

______

______

______

______

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

CLHIA ACCAP

Mental Health Conditions

Attending Physician's Statement

Section A — Plan Member/Employee Information and Consent
TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name	Group Plan Number	Canada Life Employee Identification Number	Date of Birth (dd/mm/yyyy)

Date Last Worked	**Date Returned to Work or Expected Return to Work Date, if known** (dd/mm/yyyy) ______	**Please provide your:**
(dd/mm/yyyy) ______		Height: ______ Weight: ______

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 Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life Life 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 Life for the purposes stated above. I acknowledge that my consent enables Canada Life Life 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 understand that I am responsible for any fees related to the completion of this form.

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)

Section B — Attending Physician's Questionnaire
TO BE COMPLETED BY THE DOCTOR

I am the: Attending Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) ______

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1. Diagnosis

Primary: ______

______

Secondary: ______

______

Is this condition related to: Occupational Illness/injury ☐ Auto accident ☐ If so, date of event: (dd/mm/yyyy) ______

Details: ______

______

______

Date of first visit to you pertaining to this condition (dd/mm/yyyy) ______	First date of work absence due to this condition: (dd/mm/yyyy) ______

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date: (dd/mm/yyyy) ______ By whom: ______

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.)

______

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

CLHIA ACCAP

2. Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity: ____________________

3. Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy / Vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision Making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration / Focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect / Mood	☐	☐	☐	☐
Insight / Judgment	☐	☐	☐	☐
Self-Criticism	☐	☐	☐	☐

Observations or comments supporting the above: ____________________

4. Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

☐ Workplace Issues ☐ Social / Family Issues ☐ Financial / Legal Problems

☐ Physical Condition ☐ Alcohol / Drug Abuse ☐ Medication Side Effects

☐ Pain Perception ☐ Coping Skills ☐ Personality / Motivation ☐ Other

Please describe: ____________________

Please describe the supports in place, or planned, to assist with these issues: ____________________

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

CLHIA ACCAP

5. Investigations

Please attach copies of all relevant:
- **test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**
- **do not provide genetic test results**

Are tests / investigations / consultations pending? Yes ☐ No ☐ Date report expected: (dd/mm/yyyy) ____________

Does the patient have an appointment booked with an specialist(s) in the near future? Yes ☐ No ☐

	Name of Specialist	Specialty	Date of Appointment: (dd/mm/yyyy)
1.			
2.			

Reason for requesting the consultation: ____________

____

____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐ Don't know ☐

If yes, as of when? (dd/mm/yyyy) ____________ Type of licence: ____________

6. Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response

7. Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization anticipated? Yes ☐ No ☐

	Date admitted (dd/mm/yyyy)	Date discharged (dd/mm/yyyy)	Institution Name
1.			
2.			

8. Treatment Details - Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

CLHIA ACCAP

9. Treatment Details - Concurrent Physiological Disorders, if known (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

10. Overall Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please explain: ______________________________

____

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: ______________________________

____

11. Prognosis and Recovery

What return-to-work goals have been discussed with the patient? Please explain: ______________________________

____

____

Please provide the patient's prognosis for improvement: ______________________________

Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis:

____

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

INITIAL ATTENDING PHYSICIAN'S STATEMENT

Musculo-skeletal Form

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE 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.

PLAN NO. ___________________

Part 1: Patient Authorization

Name (please print): ___________________ Date of birth: Year _________ Month ___________ Day _________

Address: Street & Number ___________________

City ___________________ Province ________________ Postal Code ___________________

Telephone Number (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 Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life Life 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 Life for the purposes stated above. I acknowledge that my consent enables Canada Life Life 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.

Patient's Signature ___________________ Date ___________________

Part 2: Attending Physician's Statement

1. **Diagnosis (please provide copies of all relevant clinical notes, test results and consultation reports. Do not provide genetic test results.)**

Primary: ___________________

Secondary: ___________________

Date symptoms first appeared Year ___________ Month _______________ Day ________

Date patient's condition first prevented them from working Year ___________ Month _______________ Day ________

Date of first visit for treatment or consultation Year ___________ Month _______________ Day ________

Has patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe: ___________________

Is condition a result of an injury due to an accident? ☐ Yes ☐ No

If yes, please describe. ___________________

Current height _________________ Current weight _________________ Weight loss / gain to date ___________________

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

If yes, have Workers' Compensation Board/CSST forms been completed? ☐ Yes ☐ No

Date of latest visit: Year ___________ Month ______________ Day ________

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other ___________________

Date of hospital inpatient admission: Year ___________ Month ______________ Day ________

Date of discharge: Year ___________ Month ______________ Day ________

Date of hospital outpatient admission: Year ___________ Month ______________ Day ________

Name of hospital: ___________________

Other treating physicians: ___________________

Pending referrals to specialists: ___________________

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company. Any modification of this document without the express written consent of Canada Life is strictly prohibited.

2. Please outline all objective studies performed / scheduled (X-rays, laboratory data, C.T. scans, etc.) and **attach copies of each report.**

Date	Procedure	Results

3. Please indicate the nature and severity of the patient's symptoms and signs.

	Please specify location(s) and physical findings	Severe	Moderate	Mild	Absent
Pain		☐	☐	☐	☐
Deformity		☐	☐	☐	☐
Muscle Spasm		☐	☐	☐	☐
Muscle Atrophy		☐	☐	☐	☐
Loss of Tendon Reflexes		☐	☐	☐	☐
Sensory Change		☐	☐	☐	☐
Motor Deficit		☐	☐	☐	☐
Straight Leg Raising Limitation		☐	☐	☐	☐
Range of Motion Limitation		☐	☐	☐	☐
Other (specify)		☐	☐	☐	☐

If Arthritic Condition: ☐ In Remission ☐ Continuously Active ☐ Stable
☐ Seasonally Active ☐ Intermittently Active ☐ Progressive

If Fracture: ☐ Closed ☐ Depressed ☐ Open ☐ Compressed ☐ Comminuted

4. **Treatment**

Medications (dose / frequency / date prescribed): ______

Physiotherapy (type, frequency, dates): ______

Surgery date (past): Year ______ Month ______ Day ______ Type: ______

Surgery date (future): Year ______ Month ______ Day ______ Type: ______

Other treatment: ______

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

5. **Limitations and Restrictions**

		Hours at one time					Total hours during day				
		<1	1-2	2-4	4-6	6-8	<1	1-2	2-4	4-6	6-8
Stand	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk on uneven surfaces	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drive	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This patient can lift/carry a maximum of:	kgs	0	5	9	14	18	23	27	32	36	41+
	lbs	0	10	20	30	40	50	60	70	80	90+
☐ No restriction	☐ Repetitively - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please indicate in the space provided if this patient is able to perform the following actions:
(Frequently (F), Occasionally (O) or Not at all (N):)

Drive ____ Bend ____ Squat ____ Kneel ____ Climb ____ Reach (above shoulders) ____ Reach (below shoulders) ____

6. **Prognosis / Return to work plans:**

Prognosis for recovery: ______________________________

Expected date patient will return to their own occupation: Year ________ Month __________ Day ______

If unknown, please indicate the next follow up date: Year ________ Month __________ Day ______

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work). ______________________________

____

Assessment and treatment are complicated by: (please select 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) ______________________________

☐ Substance abuse ______________________________

☐ Other (please describe) ______________________________

____

Rehabilitation:

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

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

If yes to either of the above, 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?

____

____

____

____

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

The patient is responsible for any fees related to the completion of this form.

CLHIA ACCAP

Other Conditions

Attending Physician's Statement - Long Term Disability Claim

Section 1 Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name	Group Plan Number	Canada Life Employee Identification Number	Date of Birth (dd/mm/yyyy)

Date Last Worked (dd/mm/yyyy)	**Date Returned to Work or Expected Return to Work Date** (dd/mm/yyyy)

Please list your present medications:

	Name of Medication	Dosage (mg)	How Often?
1.			
2.			
3.			
4.			
5.			

Please provide your:

Height: ____________

Weight: ____________

Dominant Hand:

Left ☐ Right ☐

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 Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life Life 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 Life for the purposes stated above. I acknowledge that my consent enables Canada Life Life 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) ____________________

Section 2 Attending Physician's Statement TO BE COMPLETED BY THE PHYSICIAN

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) ____________________

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1. Diagnosis

Primary: ____________________

Secondary and/or Complications: ____________________

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) ____________________

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

CLHIA ACCAP

Is this condition due to:

Occupational Illness/injury Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) ______

Auto Accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) ______

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) ______

Date of first visit to you pertaining to this condition:

(dd/mm/yyyy) ______

First date of work absence due to condition:

(dd/mm/yyyy) ______

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1**)

______

______

______

______

______

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) ______

Date of last visit: (dd/mm/yyyy) ______

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date: (dd/mm/yyyy) ______ Treatment provider: ______

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate: ______

Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: ______

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐

Is future hospitalization planned? Yes ☐ No ☐

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

canada life™

CLHIA ACCAP

Investigations

Please attach copies of all relevant:
- **test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**
- **do not provide genetic test results**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Functional Abilities

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities:

canada life™

CLHIA ACCAP

Has any licence held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy) ______________________ Type of licence: ______________________

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐ Please elaborate:

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	