

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: _____

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)	