

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

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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) \_\_\_\_\_

**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?

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**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)	