

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: \_\_\_\_\_

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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deformity		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Spasm		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Atrophy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Tendon Reflexes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Change		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Deficit		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Straight Leg Raising Limitation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Range of Motion Limitation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk on uneven surfaces	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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+
<input type="checkbox"/> No restriction	<input type="checkbox"/> Repetitively - how much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Occasionally - how much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)	