Attending Physician's Statement

MUSCULOSKELETAL DISORDERS

Patient consent

I authorize my healthcare provider to disclose my personal information, including medical and health information, to Canada Life for the purpose of investigating and assessing my claim(s), developing a rehabilitation plan to help me return to work, auditing the assessment of my claim(s), and administering the claim(s) and the group benefits plan. **Medical and health information excludes genetic test results.**

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.

A photocopy or electronic copy of this consent form is as valid as the original.

This consent may be revoked by me at any time by sending a written instruction.

Your name (please print) _____ **Date of birth** _____

Your employer's name _____ **Group plan number** _____

Your signature _____ **Date** _____

Physician's statement

- Please print
- Please answer all questions in full
- Any charges for completion of this form is the patient's responsibility

Primary Diagnosis _____

Secondary Diagnosis _____

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

If yes, indicate when and provide details:

_____

_____

Date symptoms first presented Year _____ Month _____ Day _____

Date of first visit for this condition Year _____ Month _____ Day _____

Date the patient was first prevented from working Year _____ Month _____ Day _____

Please provide:

- A copy of your clinical notes, and
- Copies of imaging reports (X-ray, Ultrasound, CT, MRI) and other test results since symptom onset (do not include genetic test results). If tests are pending, indicate the date scheduled:

Indicate your patient's symptoms, frequency and severity:

Symptom	Frequency	Severity

Findings upon physical examination:

_____

_____

Current height _____ Current weight _____ Dominant hand: Left ☐ Right ☐

Please indicate your patient's functional capabilities, noting only areas with impairment (if left blank, we will assume full function):

Endurance	Up to 4 hours continuously	2-4 hours continuously	1-2 hours continuously	up to 1 hour continuously	up to 20 mins	Unable/ Not at all	Expected duration of any restrictions
Sit	☐	☐	☐	☐	☐	☐	
Stand	☐	☐	☐	☐	☐	☐	
Walk	☐	☐	☐	☐	☐	☐	
Drive	☐	☐	☐	☐	☐	☐	

Activity		Constantly (85-100%)	Frequently (65-84%)	Regularly (34-64%)	Occasionally (33% or less)	Unable/ Not at all	Expected duration of any restrictions
Bend/Stoop		☐	☐	☐	☐	☐	
Squat/Kneel		☐	☐	☐	☐	☐	
Climb stairs		☐	☐	☐	☐	☐	
Operate foot controls	Right	☐	☐	☐	☐	☐	
	Left	☐	☐	☐	☐	☐	
Push/Pull	Right	☐	☐	☐	☐	☐	
	Left	☐	☐	☐	☐	☐	
Reach							
Below shoulder	Right	☐	☐	☐	☐	☐	
	Left	☐	☐	☐	☐	☐	
Above shoulder	Right	☐	☐	☐	☐	☐	
	Left	☐	☐	☐	☐	☐	
Hand dexterity							
Gross manipulation (grip/ grasp)	Right	☐	☐	☐	☐	☐	
	Left	☐	☐	☐	☐	☐	
Fine manipulation (type/write/grip)	Right	☐	☐	☐	☐	☐	
	Left	☐	☐	☐	☐	☐	
Lift/Carry up to 10 lbs/4.5 kgs		☐	☐	☐	☐	☐	
Lift/Carry up to 20 lbs/9.1 kgs		☐	☐	☐	☐	☐	
Lift/Carry up to 50 lbs/22.7 kgs		☐	☐	☐	☐	☐	

If there are restrictions not listed above, please indicate:

Describe the effect on activities of daily living (driving, shopping, household chores) and self-care (bathing, dressing, grooming, etc):

Have you provided advice regarding physical and psychological wellness (hurt vs harm, maintaining routines, etc.)? Yes ☐ No ☐
Please explain:

What other activities have you recommended to promote recovery?

Has surgery been performed or planned? Year _____ Month _____ Day _____

Type of surgery: _____

Other treatment (cast, mobility aids, physio, orthotics, etc.):

Indicate the current medication(s), dosage(s), and when these were prescribed:

Medication	Current dosage	When current dosage was prescribed	Dosage changes

Is medication management optimal? Yes ☐ No ☐ If not, please elaborate:

What has been the response to treatment to date:

Upcoming changes to the treatment program:

Other treating physicians (please provide copies of the consultation reports):

Pending referrals: _____

Expected return to work date: _____ **OR** ☐ Unknown **OR** ☐ Not expected to return

Canada Life supports return to work efforts such as modified/alternate duties, part-time or transitional work, as being part of the recovery process. What return to work goals have been discussed/do you recommend?

Please outline any factors which may complicate recovery or create a barrier to return to work:

Please include any additional information you care to provide:

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)	

Clear