

# CERTIFICATE OF ATTENDING PHYSICIAN DISMEMBERMENT OR LOSS

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_ ID Number: \_\_\_\_\_

1. (a) When did the accident happen? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(b) Briefly describe details of the accident. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. (a) Date of first attendance for present injury. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(b) Date of most recent treatment. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

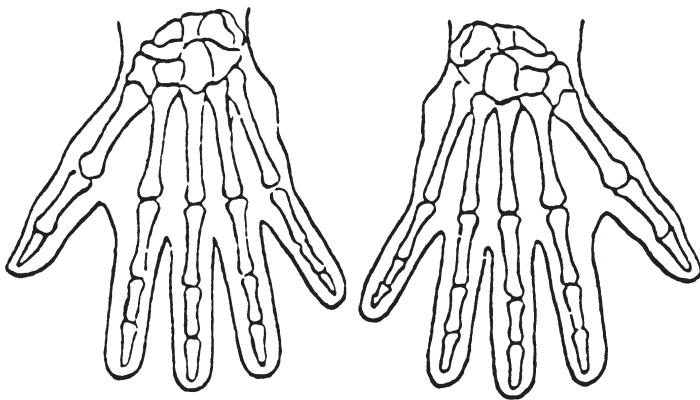
**DISMEMBERMENT**

3. (a) If the accident caused the loss of hand, foot, leg, arm, fingers, toes, please indicate the specific joint level of the amputation on the diagram below.

- Hand     Foot     Leg     Arm     Fingers     Toes

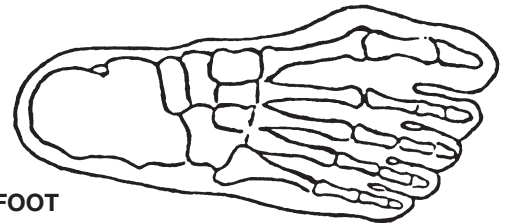
(b) Date of amputation. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(c) Please include surgery report and hospital admittance and discharge summary.

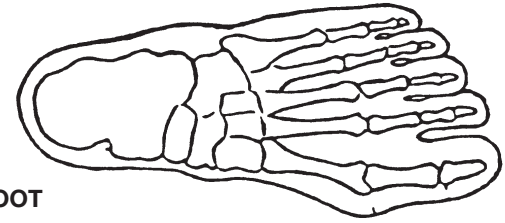


LEFT HAND

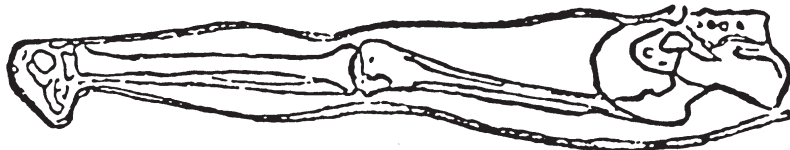
RIGHT HAND



RIGHT FOOT



LEFT FOOT



INDICATE WHETHER RIGHT OR LEFT



4. (a) If the accident caused total and irrecoverable loss of sight, hearing or speech, please indicate which:

Sight    Hearing    Speech

(b) Date on which loss occurred.                      Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(c) Is there any possibility of improvement to the injured area?    Yes    No

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#### LOSS OF VISION

(a) If known to you, please advise the vision in each eye prior to the accident.

\_\_\_\_\_

(b) What is the best corrected vision in the affected eye(s), if any?

\_\_\_\_\_

(c) Please include visual acuity results and Ophthalmologist report.

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#### LOSS OF HEARING

(a) Is there any indication that hearing was abnormal prior to accident?

\_\_\_\_\_

(b) Level of hearing at date of loss.

\_\_\_\_\_

(c) Please include Audiologist report and hearing test.

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#### LOSS OF SPEECH

(a) If known to you please advise if the insured was able to speak intelligibly prior to accident.

\_\_\_\_\_

(b) Is insured's speech intelligible at the present time?

\_\_\_\_\_

(c) Please include Speech Therapy assessment.

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#### LOSS OF USE

5. (a) If the accident caused loss of use of leg, arm, or hand, please advise which.

Leg    Arm    Hand

(b) Is there any indication that the injured limb was unable to function normally prior to accident?    Yes    No

(c) Please indicate what functions, if any, the injured limb is able to perform.

\_\_\_\_\_

(d) Is there any possibility of improvement to the injured area?    Yes    No

(e) Please include: Hospital admittance and discharge summary, surgery report (if relevant), Range of Motion test results and Physiotherapist / Occupational Therapist reports, consultation and progress reports, Neurologic exam (paraplegia / quadriplegia).

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6. (a) Was the injury described solely responsible for the loss?    Yes    No

(b) If not, give particulars of any contributing cause or causes.

\_\_\_\_\_

\_\_\_\_\_

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Print Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_ M.D.

Address \_\_\_\_\_  
Street                                      City                                      Province                                      Postal Code

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