

- 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.

Part 1: Patient Authorization

Name:		Date of Birth: (dd/mm/yy)	
Our Reference			
I, _____ hereby authorize the release to my insurer any information including consultation reports and tests with respect to this claim.			
Patient Signature:			Date (dd/mm/yy)

Part 2: Attending Physician's Statement

Primary Diagnosis (please use DSM IV Criteria for mental/psychiatric conditions) :			
Additional Conditions or Complications:			
Subjective Symptoms (including severity and frequency):			Current GAF Score (Global Assessment of Functioning)
Objective findings on examination:			
Date of latest attendance (dd/mm/yy)		Hospital Admission and Discharge Dates (dd/mm/yy)	
Current prescribed medications and dosages:			
Name			
Initial Dose			
Current Dose			
Date of Last dose change			
Other treatment (e.g.: physiotherapy, counselling, etc.):			
Future treatment plans (e.g.: pending referrals, imaging, surgeries):			

Name:		Date of Birth: (dd/mm/yy)	
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Expected Recovery / Return to Work date: (dd/mm/yy)

Can your patient return to work on gradual basis or any other occupation at this time?

Prognosis for recovery:

<i>Current functional Limitations</i>				
Function:	Degree of Limitation			
	None	Slight	Moderate	Severe
Cognition				
Speaking				
Hearing				
Vision				
Psychological				
Sensation				
Dexterity				

Activity:	Degree of Limitation	
	Duration / Weight	Frequency
Driving		
Walking		
Standing		
Climbing		
Sitting		
Bending		
Lifting		
Dexterity		

Additional Comments:

Name of Attending Physician (please print)	Specialty:	Telephone:
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Address

Signature of Physician	Date (dd/mm/yy)
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