Attending Physician's Statement

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):				

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Attending Physician's Statement

Name:		Date of Birth: (dd/mm/yy)	

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:

Current functional Limitations

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:
Address		
Signature of Physician		Date (dd/mm/yy)

PLEASE SUBMIT COMPLETED FORM TO:

THE CANADA LIFE ASSURANCE COMPANY
CREDITOR INSURANCE – CLAIMS DEPARTMENT
330 UNIVERSITY AVENUE, TORONTO, ONTARIO, CANADA M5G 1R8
FAX NO.: 416-552-6557

E-MAIL ADDRESSES :
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Clear