canada life™

INITIAL ATTENDING PHYSICIAN'S STATEMENT

Musculo-skeletal Form

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		☐	☐	☐	☐
Deformity		☐	☐	☐	☐
Muscle Spasm		☐	☐	☐	☐
Muscle Atrophy		☐	☐	☐	☐
Loss of Tendon Reflexes		☐	☐	☐	☐
Sensory Change		☐	☐	☐	☐
Motor Deficit		☐	☐	☐	☐
Straight Leg Raising Limitation		☐	☐	☐	☐
Range of Motion Limitation		☐	☐	☐	☐
Other (specify)		☐	☐	☐	☐

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	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk on uneven surfaces	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drive	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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+
☐ No restriction	☐ Repetitively - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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)	

Clear