MEDAVIE BLUE CROSS™

ATTENDING PHYSICIAN STATEMENT

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INSTRUCTIONS:

1. Please write in block letters.
2. Part I to be completed by the patient.
3. Part II to be completed by the physician.
4. Any charge related to completing this form is the patient's responsibility.

PART I: PATIENT AUTHORIZATION

Name: _____ Date of Birth: _____ | _____ | _____
Last name First name Initial(s): YYYY MM DD

I herewith authorize the disclosure of the information requested by my insurer or its advisors.

Signature: _____ Date: _____ | _____ | _____
YYYY MM DD

PART II: ATTENDING PHYSICIAN'S STATEMENT

Name: _____ Specialization: _____

Address: _____

_____

_____

Telephone: ( ) _____ Fax: ( ) _____

CURRENT CONDITION

Date of initial examination: _____ | _____ | _____
YYYY MM DD

Date of most recent visit: _____ | _____ | _____
YYYY MM DD

Date of next examination: _____ | _____ | _____
YYYY MM DD

Frequency of follow-up: _____

Primary diagnosis: _____

_____

_____

Secondary diagnosis: _____

_____

_____

Symptoms: _____ Signs: _____

_____ _____

_____ _____

_____ _____

Severity level of symptoms as a whole: ❑ minor ❑ moderate ❑ severe

Has the patient had: ❑ a diagnostic test ❑ a consultation ❑ been hospitalized
If yes, it is important that you attach copies of all results, consultation reports and hospital discharge reports.

Physical or cognitive functional limitations or restrictions (please specify maximum duration or maximum weight):

_____

_____

_____

Are the limitations: ❑ permanent ❑ temporary

Time scheduled for convalescence: _____

If condition is related to pregnancy, state the date or expected date of delivery:

_____ | _____ | _____
YYYY MM DD

Is the condition due to injury or sickness arising from the patient's employment? ❑ yes ❑ no ❑ unknown

Factors likely to influence convalescence (please explain).

- ❑ Dependency _____
- ❑ Diet _____
- ❑ Work environment _____
- ❑ Home environment _____
- ❑ Family history of current condition _____
- ❑ General physical condition _____
- ❑ Medical history _____
- ❑ Pre-existing conditions _____

Has the patient previously had a similar condition? ❑ yes ❑ no If yes, please elaborate.

_____

_____

_____

Current treatment plan

Please state the current / planned treatment: Date YYYY MM DD

- ❑ Medications (including doses)

_____ _____

_____ _____

- ❑ Surgery YYYY MM DD

_____ _____

	Name	Specialization	YYYY MM DD
❑ Chiropractor			
❑ Counsellor			
❑ Diagnostic test / analysis			
❑ Specialist			
❑ Therapist			
❑ Other			

Patient progress:

- ❑ None
- ❑ Regression
- ❑ Minimal improvement
- ❑ Significant improvement
- ❑ Cure
- ❑ Plateau

Date of return to work:

- ❑ light work: _____ **(please complete the attached forms)**
- ❑ phased return to work, please specify: _____
- ❑ full-time working: Date: _____ (YYYY MM DD)

In your opinion, is the patient a suitable candidate for a rehabilitation/reactivation program?
❑ yes ❑ no If no, please give details.

Other information that may be useful or important for the recovery of the patient:

_____

_____

_____

_____

Signature: _____ Date: _____ (YYYY MM DD)