MEDAVIE BLUE CROSS™

ATTENDING PHYSICIAN'S STATEMENT
CRITICAL CONDITION BENEFIT

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PART 1: PATIENT AUTHORIZATION

Patient's Name: _____ Date of Birth (DD/MM/YYYY): _____

I hereby authorize the release to my insurer and my policyholder of any information in respect of this application.

Patient's Signature: _____ Date (DD/MM/YYYY): _____

PART 2: ATTENDING PHYSICIAN'S STATEMENT

For cancer diagnoses please include a copy of the pathology report.

Diagnosis:

A) Primary

B) Secondary

C) Additional conditions or complications

Date symptoms appeared (DD/MM/YYYY): _____ Has patient ever had same or similar condition? ○ Yes ○ No

If yes, give dates and details:

Date patient first received medical treatment, diagnostic measures, medication, or consultation for this condition (DD/MM/YYYY): _____

Date of last treatment for this condition, if different from above:
(DD/MM/YYYY) _____

Date of last treatment for this condition:
(DD/MM/YYYY) _____

Was patient in hospital? ○ Yes ○ No

Name and address of hospital:

Date of hospital treatment

Outpatient: _____ (DD/MM/YYYY) **OR** Inpatient Admission: _____ (DD/MM/YYYY) Discharge: _____ (DD/MM/YYYY)

Surgical treatment, if any: _____

Details: _____

Date (DD/MM/YYYY): _____

Are you aware of other physician(s) who treated this patient due to this present condition? ○ Yes ○ No

If yes, please give name(s) and address(es):

Do you believe the patient is competent to endorse cheques and direct the use of proceeds? ○ Yes ○ No

Please summarize your patient's medical history (attach copies of tests administered including the results of any relevant clinical findings).

List all objective findings:

List all subjective findings:

Please indicate how activities of daily living are affected by this condition.

Eating

Dressing

Bathing

Ambulation

Toileting

Cardiac functional capacity (if applicable).
(Canadian Cardiovascular Society)

- ○ Class 1 — No limitations
- ○ Class 2 — Slight limitations
- ○ Class 3 — Marked limitations
- ○ Class 4 — Complete limitations

Please forward results of stress tests, angiogram, etc.

Please outline your prognosis for this patient (refer to the list of critical conditions):

Remarks:

Physician's Name (Print): _____

Address:

Telephone No.: _____ Signature: _____ Date (DD/MM/YYYY): _____