MEDAVIE BLUE CROSS™

ATTENDING PHYSICIAN'S STATEMENT - GENERAL

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INSTRUCTIONS:

1. Please Print.
2. Part I to be completed by patient.
3. Part II through VI to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

PART I: PATIENT AUTHORIZATION

Name: ______________________________ Date of Birth (DD/MM/YYYY): ______________
Last First Initial

I hereby authorize the release of any information herein requested by my insurer or its agents.

Signature: ______________________________ Date (DD/MM/YYYY): ______________

PART II: ATTENDING PHYSICIAN'S STATEMENT

Name: ______________________________ Specialty: ______________

Address: ______________________________

____

Telephone: ______________________________ Fax: ______________

PART III: HISTORY OF PRESENT CONDITION(S) *Please note, medical and health information excludes genetic test results.*

1. If the condition is related to pregnancy, indicate the date or expected date of delivery (DD/MM/YYYY): ______________
(Please attach prenatal clinical notes)

2. Is the condition due to injury or sickness arising out of the patient's employment? ❑ Yes ❑ No ❑ Unknown
Have Workers' Compensation/CSST forms been completed? ❑ Yes ❑ No ❑ Unknown

3. a) Primary Diagnosis: ______________________________ Scale: DSM ( ) Grade ( )
______________________________ Class ( ) Stage ( )

b) Secondary Diagnosis: ______________________________ Scale: DSM ( ) Grade ( )
______________________________ Class ( ) Stage ( )

c) Date symptoms first appeared or accident happened (DD/MM/YYYY): ______________

d) Initial Examination Date (DD/MM/YYYY): ______________

e) Date patient ceased working due to this condition (DD/MM/YYYY): ______________

f) Symptoms (include severity and frequency): ______________

____

g) Clinical Findings **(Please attach copies of X-rays, test results, etc)**: ______________

____

h) Functional Limitations/Restrictions **(Please specify length of time or maximum weight)**
Sitting: ________ Standing: ________ Walking: ________ Lifting: ________ Carrying: ________ Bending: ________

i) Expected duration of restriction/limitations: ______________

PART IV: FACTORS AFFECTING RECOVERY

❑ Addiction ______________

❑ Diet ______________

❑ Work Environment ______________

❑ Home Environment ______________

❑ Family History of Present Condition ______________

❑ Current: Height: ________ Weight: ________ Right or left hand dominant: ________

❑ Past Medical History ______________

❑ Pre-existing Conditions ______________

Has the patient previously had a similar condition? ❑ Yes ❑ No If yes, please specify date of initial onset. ______________

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Name of Patient: ____________________

PART V: MANAGEMENT PLAN FOR THE CURRENT CONDITION

	Date YYYY	MM	DD
❑ Frequency of visits: ____			
❑ Date of most recent visit: ____			
❑ Date of re-evaluation: ____			
❑ Hospitalization dates - **Please include Admission/Discharge Summaries** ____			
____			
____			
____			
❑ Surgery date(s) and type - **Please include Operative Report** ____			
____			
____			
❑ Medication - **(Please include dosage and date first prescribed)** ____			
____			
____			
____			

	Name	Specialty	YYYY	MM	DD
❑ Specialist					
❑ Chiropractor					
❑ Counsellor					
❑ Additional Planned Testing					
❑ Therapist					
❑ Other					

Is patient following the recommended treatment program? ❑ Yes ❑ No

PART VI: ESTIMATED TIME FOR RECOVERY

Patient Progress: ❑ None ❑ Regressed ❑ Minimal Improvement ❑ Significant Improvement ❑ Plateaued ❑ Resolved

Prognosis: ❑ Poor ❑ Good

Expected duration of recovery period: ____________________

In your opinion, is the patient a suitable candidate for medical or functional rehabilitation (i.e. conditioning program, counselling, etc.)?
❑ Yes ❑ No Please elaborate on your opinion:

____

____

In your opinion, is the patient a suitable candidate for a work re-entry program (i.e. ease back, modified duties, gradual return to work, etc.)?
❑ Yes ❑ No Please elaborate on your opinion:

____

____

Please specify any additional information or details that may have a significant impact on the patient's recovery from this condition:

____

____

____

Physician Signature: ____________________ Date (DD/MM/YYYY): ____________________