MEDAVIE BLUE CROSS™

Travel Plan Programs
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ATTENDING PHYSICIAN DECLARATION TRIP CANCELLATION

To be completed by the physician. Any professional fees charged are the insured's responsibility.

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________

Gender: ❑ Male ❑ Female Date of Birth: ____ (Year / Month / Day)

Policy Number: ____________________ Identification Number: ____________________

ATTENDING PHYSICIAN'S STATEMENT - SECTION A

If cause of cancellation is due to a death, please provide the cause and date of death below, then refer to section B for further details relating to the cause of death.

Name of Deceased: ____________________

Cause of Death: ____________________ Date of Death: ____ (Year / Month / Day)

ATTENDING PHYSICIAN'S STATEMENT - SECTION B

Diagnosis or nature of the injury or illness: ____________________

Date the accident happened or first symptoms of the illness appeared: ____ (Year / Month / Day) Date of first consultation: ____ (Year / Month / Day)

Has this person ever suffered from this illness before? ❑ Yes ❑ No If so, please specify the date: ____ (Year / Month / Day)

Was the patient hospitalized due to this condition? ❑ Yes ❑ No

If so, please specify the dates: ____ (Year / Month / Day) To: ____ (Year / Month / Day)

List all visits and/or treatment dates for this condition from initial consultation to present:

____ (Year / Month / Day) ____ (Year / Month / Day) ____ (Year / Month / Day) ____ (Year / Month / Day) ____ (Year / Month / Day)

Is this condition the complication of an underlying condition? ❑ Yes ❑ No If so, please specify: ____________________

____

Was this patient referred to you by another doctor? ❑ Yes ❑ No If so, specify the referral date: ____ (Year / Month / Day)

Name and address of the referring doctor: ____________________

____

MEDICAL RECOMMENDATION AS TO THE CAPACITY OF TRAVELLING

Is this patient the person travelling? ❑ Yes ❑ No If so, was this patient unable to travel due to this illness or injury? ❑ Yes ❑ No

Indicate the date on which you recommended the trip be cancelled: ____ (Year / Month / Day)

Dates recommended not to travel: ____ (Year / Month / Day) To: ____ (Year / Month / Day)

Are there any other reasons why this patient should not travel? ____________________

____

COMMENTS

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PHYSICIAN IDENTIFICATION AND SIGNATURE

Name and address of the physician (Please Print): ____________________

____

Specialty: ____________________ Telephone: ____________________

Physician Signature: ____________________ Date: ____ (Year / Month / Day)

Physician's Stamp

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