

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
	_____	_____	_____	_____
		YYYY	MM	DD
☐ Chiropractor	Name _____ Specialization _____	_____	_____	_____
☐ 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