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 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: _____
Last First Initial YYYY MM DD

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

Signature: _____ Date: _____
YYYY MM DD

PART II: ATTENDING PHYSICIAN'S STATEMENT

Name: _____ Specialty: _____

Address: _____

_____

Telephone: ___ - ___ - _____ Fax: ___ - ___ - _____

PART III: HISTORY OF PRESENT CONDITION(S)

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

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: _____
YYYY MM DD

d) Initial Examination Date: _____
YYYY MM DD

e) Date patient ceased working due to this condition: _____
YYYY MM DD

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 _____ ❑ Family History of Present Condition _____

❑ Diet _____ ❑ Current: Height: _____ Weight: _____ Right or left hand dominant: ___

❑ Work Environment _____ ❑ Past Medical History _____

❑ Home Environment _____ ❑ Pre-existing Conditions _____

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

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:

_____

_____

_____

Signature: _____ Date: _____ (YYYY MM DD)