ATTENDING PHYSICIAN'S UPDATE

Instructions:

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

PART 1: PATIENT AUTHORIZATION

Policy No.: _____

Name: _____ Date of Birth ____ /____ /____
(Please print) DD MM YY

Address: _____
(Number, Street, City)

_____ Phone No.: _____
(Province, Postal Code)

I hereby authorize the release of any information in respect of this claim, to my insurer, its reinsurer, and my policyholder.

Patient's Signature: _____ ____ /____ /____
DD MM YY

PART 2: PHYSICIAN'S UPDATE

1. Diagnosis given on last update for _____ on ____ /____ /____
DD MM YY

2. Are you currently treating? ☐ Yes ☐ No Date of last visit: _____
Names of other treating physician's: _____

3. Do you see this patient on:
_____ an as needed basis
_____ a regular basis: weekly ____
monthly ____
other ____ Specify _____

4. List current medication, frequency, and strength/treatment (including surgery, physio, etc.):

_____

_____

_____

To your knowledge is medication being taken as prescribed? ☐ Yes ☐ No - please comment

_____

5. Is the current diagnosis different from that described in 1 above? ☐ Yes ☐ No
Please advise new diagnosis or changes that have occured since last submission below.

6. What physical limitations affect the claimant's ability to perform acts of daily living?

7. What physical limitations affect the claimant's ability to work (eg. limitations with respect to lifting, carrying, standing, bending, walking?)

Progress: Has patient ☐ improved ☐ not improved ☐ retrogressed

8. Prognosis: _____

9. Remarks: Please provide comments and further details which you feel would be helpful.

Name of Attending Physician (please print) _____

Specialty: _____ Telephone No.: (____)_____

Address: _____
(Number, street, city, province, postal code)

Signature: _____ Date:____ /____ /____
DD MM YY

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