ATTENDING PHYSICIAN'S STATEMENT

Employee Information and Consent - TO BE COMPLETED BY THE PATIENT

Name of Employee (first, middle, last)			
Address (street, number)	City	Province	Postal code
◯ Male ◯ Female / Date of birth (dd/mmm/yy)	Phone number		
Name of Employer	Group policy number	Division number	Certificate number

I authorize the release of medical and health information in my file to The Empire Life Insurance Company and/or its authorized agents for the purpose of assessing my claim. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records.
I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.
I understand that I am responsible for any fees related to the completion of this form.
I agree that a copy or electronic version of this authorization shall be as valid as the original.
Medical and health information excludes genetic test results.

Employee signature X	Date (dd/mmm/yy)

The patient is responsible for any fees related to the completion of this form.

Attending Physician's Statement - TO BE COMPLETED BY THE PHYSICIAN

Height ◯ cm ◯ inch	Weight ◯ lb ◯ kg	Date of most recent visit (dd/mmm/yy)

Primary diagnosis:

Associated conditions which may prolong the disability:

History - please complete relevant sections on page 2 for specific disabilities

Date symptoms first appeared or accident happened (dd/mmm/yy)	Date of first visit for the present condition (dd/mmm/yy)
Date patient was medically unfit to work due to the present condition (dd/mmm/yy)	How often has the patient been seen?

Is the condition due to injury or sickness arising out of patient's employment? ◯ no ◯ yes O unknown

Has the patient ever had the same or a similar condition? ◯ no ◯ yes – please describe:

Is the condition considered chronic? ◯ no ◯ yes – what precipitated the absence from work?

Has the patient returned to work? ◯ no ◯ yes – specify date (dd/mmm/yy):

Licence Restriction

Has the patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the disability? ◯ no ◯ yes – please specify the following:

Type of licence	Class (if applicable)	Restriction date (dd/mmm/yy)

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Please complete only those sections applicable to the patient's primary or associated condition

Visual Impairment ○ Not applicable

What was the patient's vision at the last testing?	O.D.	O.S.
With glasses		
Without glasses		

Can the patient's vision be restored in whole or in part by any of the following? O no O yes – please specify:

O.D.: ○ Lenses ○ Treatment ○ Operation ○ Non-restorable

O.S.: ○ Lenses ○ Treatment ○ Operation ○ Non-restorable

Indicate nature of treatment, and date if an operation is scheduled:

Physical Impairment ○ Not applicable

- ○ Class 1 – No limitation of functional capacity, capable of heavy work. No restrictions. (0-10%)
- ○ Class 2 – Slight limitation of functional capacity, capable of light to moderate manual activity. (15-30%)
- ○ Class 3 – Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity. (35-55%)
- ○ Class 4 – Marked limitation of functional capacity, capable of minimal (sedentary) activity. (60-70%)
- ○ Class 5 – Severe limitation of functional capability, incapable of minimal (sedentary) activity. (75-100%)

What are the limitations (bending, lifting, etc.)? For each of the following, indicate by marking the appropriate response(s):

The patient can lift up to:
○ 10 pounds ○ 20 pounds ○ 50 pounds ○ 100 pounds ○ over 100 pounds ○ none

The patient can frequently lift-carry:
○ Up to 10 pounds ○ Up to 25 pounds ○ Up to 50 pounds ○ over 50 pounds ○ none

The patient can: ○ Climb ○ Kneel ○ Stoop ○ Reach ○ Crawl ○ Crouch ○ Hear ○ Grip ○ Balance

Cardiac Impairment ○ Not applicable

Specify the patient's blood pressure at last visit: Systolic _____ Diastolic _____

What is the functional capacity of the patient's heart? (based on the American Heart Association's definitions)
○ Class 1 (no limitation) ○ Class 2 (slight limitation) ○ Class 3 (marked limitation) ○ Class 4 (complete limitation)

Psychological/Psychiatric Impairment ○ Not applicable

What are the symptoms that the patient is displaying that indicate a mental impairment exists?

How does the patient's psychological/psychiatric impairment affect his/her ability to work?

How does the patient's home life situation contribute to his/her current condition? Please explain.

Is the patient's condition related to job dissatisfaction or difficulties in the workplace? ○ no ○ yes – please explain:

Has there been a psychiatric referral? ○ no ○ yes – please provide details:

What is the diagnosis(es) using the DSM IV and GAF?

Do you believe the patient is competent to endorse cheques and direct the use of the proceeds? ○ yes ○ no
If no, from what date? (dd/mmm/yy) _____

Symptoms

Subjective symptoms and severity:

Objective clinical findings and significant results from investigation (x-ray, lab, etc.): Please enclose a copy of reports.

Is or was the patient:	If yes please provide dates:
○ Bed confined ○ House confined ○ Hospital confined	

Is the condition due to pregnancy? ○ no ○ yes – what is the EDC or actual delivery date?
(dd/mmm/yy) _____

Treatment

Current treatment (include medications dose and frequency, physiotherapy and surgery)

Is the patient following recommended treatment? ○ yes ○ no – please comment:

Has the patient refused any recommended treatment or investigation? ○ no ○ yes – please comment:

Other medical advisors (including physiotherapists) the patient has seen or been referred to regarding the current disability:

Name	Address	Date (dd/mmm/yy)

Prognosis

Has the patient: ○ Recovered ○ Improved ○ Unchanged ○ Deteriorated

What is your prognosis for recovery?

Has the patient achieved maximal medical improvement? ○ yes ○ no – how soon do you expect fundamental changes in the patient's medical condition?

○ 1-2 months ○ 3-4 months ○ 5-6 months ○ Indefinite ○ Never ○ Other _____

Rehabilitation

Is the patient a suitable candidate for medical rehabilitation? ○ yes ○ no

Would vocational rehabilitation be recommended? ○ yes ○ no

What factors are likely to limit the effectiveness of the patient's rehabilitation?

Have you discussed a return to work plan with the patient? ○ no ○ yes – on what basis?

○ Part-time – from (dd/mmm/yy) _____ to (dd/mmm/yy) _____ ○ regular or ○ modified work

○ Full-time modified work – from (dd/mmm/yy) _____ to (dd/mmm/yy) _____

○ Full-time regular work – from (dd/mmm/yy) _____ to (dd/mmm/yy) _____

Additional Comments

Attending Physician

The information in this statement will be kept in a life, health, or disability benefits file with the plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.
By providing the information I consent to such unedited release of any information contained herein.

Name of Attending Physician (please print)		Specialty	
Address (number and street)	City	Province	Postal code
Telephone number	Fax number	Email address	
Physician's signature X		Date (dd/mmm/yy)	

Please return to:

Life & Disability Claims
Group Solutions
The Empire Life Insurance Company
259 King Street East
Kingston ON K7L 3A8

Toll free phone # 1 800 267-0215
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