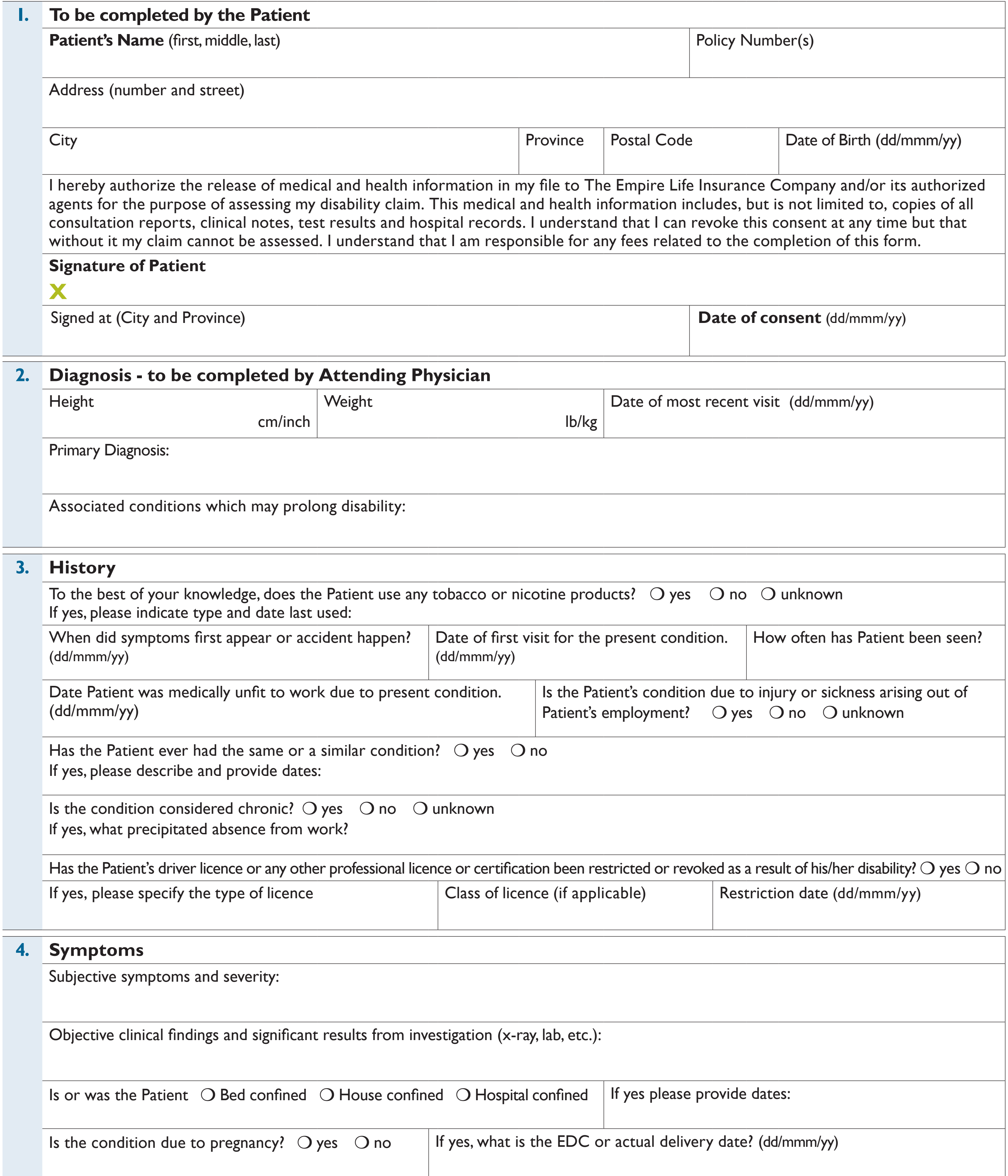
ATTENDING PHYSICIAN'S STATEMENT

To be completed by the physician who is attending the Patient during the present disability.
Original signatures must be submitted to Empire Life. *The patient is responsible for charges incurred for the completion of this form.*



1. To be completed by the Patient

Patient's Name (first, middle, last) | Policy Number(s)

Address (number and street)

City | Province | Postal Code | Date of Birth (dd/mmm/yy)

I hereby 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 disability 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.

Signature of Patient
X

Signed at (City and Province) | **Date of consent** (dd/mmm/yy)

2. Diagnosis - to be completed by Attending Physician

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

Primary Diagnosis:

Associated conditions which may prolong disability:

3. History

To the best of your knowledge, does the Patient use any tobacco or nicotine products? ❍ yes ❍ no ❍ unknown
If yes, please indicate type and date last used:

When did symptoms first appear or accident happen? (dd/mmm/yy) | Date of first visit for the present condition. (dd/mmm/yy) | How often has Patient been seen?

Date Patient was medically unfit to work due to present condition. (dd/mmm/yy) | Is the Patient's condition due to injury or sickness arising out of Patient's employment? ❍ yes ❍ no ❍ unknown

Has the Patient ever had the same or a similar condition? ❍ yes ❍ no
If yes, please describe and provide dates:

Is the condition considered chronic? ❍ yes ❍ no ❍ unknown
If yes, what precipitated absence from work?

Has the Patient's driver licence or any other professional licence or certification been restricted or revoked as a result of his/her disability? ❍ yes ❍ no

If yes, please specify the type of licence | Class of licence (if applicable) | Restriction date (dd/mmm/yy)

4. Symptoms

Subjective symptoms and severity:

Objective clinical findings and significant results from investigation (x-ray, lab, etc.):

Is or was the Patient ❍ Bed confined ❍ House confined ❍ Hospital confined | If yes please provide dates:

Is the condition due to pregnancy? ❍ yes ❍ no | If yes, what is the EDC or actual delivery date? (dd/mmm/yy)

5. Treatment

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

Is the Patient following recommended treatment? ❍ yes ❍ no If no, please comment:

Has the Patient refused any recommended treatment or investigation? ❍ yes ❍ no If yes, please comment:

List other medical advisors the Patient has seen or been referred to regarding the current disability

Name	Speciality	Address	Date (dd/mmm/yy)

6. Prognosis

Has the Patient ❍ Recovered ❍ Improved ❍ Unchanged ❍ Deteriorated

What is your prognosis for recovery?

Has the Patient achieved maximal medical improvement? ❍ yes ❍ no If 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

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?

7. Return to Work Plan

Have you discussed a return to work plan with the patient? ❍ yes ❍ no

If yes, on what basis? ❍ Part-time - from ______________________ to ______________________ ❍ Regular Work ❍ Modified Work

❍ Full-time modified work - from __________________ to __________________

❍ Full-time regular work - return date ____________________________________

If a graduated return to work program is planned provide details:

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

8. 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 ❍ over100 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

9. Cardiac Impairment ❍ Not Applicable

What was 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)

10. 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? If yes, please explain.

Has there been a psychiatric referral? If 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, then from what date? (dd/mmm/yy)

11. Visual Impairment ❍ Not applicable

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

Can the Patient's vision be restored in whole or in part by:

		Indicate nature of treatment, and date if an operation is scheduled:
O.D.	❍ Lenses ❍ Treatment ❍ Operation ❍ Non-restorable	
O.S.	❍ Lenses ❍ Treatment ❍ Operation ❍ Non-restorable	

12. Additional Comments:

13. Attending Physician

The information in this statement will be kept in a life, health, or disability benefits file with the plan insurer 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)			Telephone Number
City	Province	Postal Code	Fax Number
Physician's Signature X			**Date** (dd/mmm/yy)

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