MEDAVIE BLUE CROSS™

ATTENDING PHYSICIAN'S STATEMENT

644 MAIN ST PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-800-667-4511
FAX: 1-800-644-1722

230 BROWNLOW AVE DARTMOUTH
PO BOX 2200 HALIFAX NS B3J 3C6
TEL: 1-800-667-4511
FAX: 1-800-644-1722

PO BOX 2000 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-800-355-9133
FAX: 416-626-0400

PO BOX 668 STATION B
MONTREAL QC H3B 3K3
TEL: 1-800-456-6595
FAX: 1-844-244-8198
salaire@medavie.bluecross.ca

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: ( ) _____

PRESENT CONDITION(S)

Initial Examination Date: _____ | _____ | _____
YYYY MM DD

Primary Diagnosis: _____ Scale: DSM ( ) Grade ( )
_____ Class ( ) Stage ( )
_____
_____

Secondary Diagnosis: _____ Scale: DSM ( ) Grade ( )
_____ Class ( ) Stage ( )
_____
_____

Symptoms: _____ Signs: _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Has there been: ❑ Diagnostic Testing ❑ Consultation ❑ Hospitalization
If so, it is important that you attach copies of all results, consultation reports and hospital discharge summaries.

Permanent functional limitations/restrictions are probable ❑ Yes ❑ No

Estimated time for recovery: _____

If condition is related to pregnancy, indicate date or expected date of delivery: _____ | _____ | _____
YYYY MM DD

Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No ❑ Unknown

Factors that may affect recovery (please explain)

- ❑ Addiction _____
- ❑ Diet _____
- ❑ Work Environment _____
- ❑ Home Environment _____
- ❑ Family History of Present Condition _____
- ❑ General Fitness _____
- ❑ Past Medical History _____
- ❑ Pre-existing Conditions _____

Has the patient previously had a similar condition? ❑ Yes ❑ No If yes, please explain.

_____

_____

_____

Management Plan for the Current Condition

Please indicate active/future treatment:

Date YYYY MM DD

❑ Medication (include dosage)

_____ _____

_____ _____

_____ _____

_____ _____

❑ Surgery YYYY MM DD

_____ _____

_____ _____

	Name	Specialty	Date YYYY MM DD
❑ Chiropractor	_____	_____	_____
❑ Counsellor	_____	_____	_____
❑ Diagnostic Testing	_____	_____	_____
❑ Specialist	_____	_____	_____
❑ Therapist	_____	_____	_____
❑ Other	_____	_____	_____

Patient Progress:

- ❑ None
- ❑ Regressed
- ❑ Minimal Improvement
- ❑ Significant Improvement
- ❑ Resolved
- ❑ Plateaued

In your opinion, is patient a suitable candidate for a work re-entry program (ie. ease back, modified duties, gradual return to work, etc.)? ❑ Yes ❑ No If no, please explain in detail.

_____

_____

_____

Other information that may be helpful or important to the patient's recovery from this condition:

_____

_____

_____

_____

Signature:_____ Date: _____ (YYYY MM DD)