Canada Life™

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.***

Attending Physician's Statement For Disability Benefits

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM
IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL**.

Policy and Certificate No.

Part 1: Patient Authorization

Name

Date of Birth (day, month, year)

Address (number, street, city, province, postal code)

I certify that the above statements are true and I hereby authorize The Canada Life Assurance Company and its authorized agents, including its legal representatives and investigators to obtain, receive, examine, copy and disclose any records or knowledge of me or my health, **INCLUDING CONSULTATION REPORTS**, from, or give to, any employer, physician, medical practitioner, hospital, clinic, attorney, investigative agency, insurance company and insurance support organization.

The purpose for which this information is collected is: i) to adjudicate my claim, ii) for the employer's and policyholder's statistical purposes, and iii) for whatever purposes the employer, policyholder and insurer so require.

A photographic copy of this authorization shall be as valid as the original. I hereby authorize the use of my Social Insurance Number for the administration of the benefits under this group policy.

Patient's Signature

Date (day, month, year)

Part 2: Attending Physician's Questionnaire

1. DIAGNOSIS OF PRESENT CONDITION

Primary _____

Secondary _____

Has patient had same or similar condition in the past?

Yes No If "Yes", provide date(s) (day, month, year) ____ /____ /____ ____ /____ /____ ____ /____ /____

Date first seen ____ /____ /____ Date last seen____ /____ /____ Frequency of visits: Weekly Monthly Other _____

Other treating physicians _____

2. SYMPTOMS

Pain in the (cervical, thoracic, lumbosacral) area **(circle one or more)**

Stiffness or impaired range of motion

Subjective weakness or incoordination

Parasthesias or sensory disturbance in radicular or dermatomal pattern in the (arms(s), leg(s), trunk) **(circle one or more)**

Other **(please specify)** _____

3. PHYSICAL FINDINGS

Distinct muscle spasm

Loss or distortion of normal spine curves

Neurological deficits: **Power** Yes No If yes, explain _____

Sensory Loss Yes No If yes, explain _____

Reflexes Yes No If yes, explain _____

Specific reliable and reproducible signs **(please list)** _____

Limitation of movement:

Forward flexion _____ degrees Rotation _____ degrees Lateral flexion _____ degrees SLR _____ degrees

Limitations preventing return to work _____

4. TREATMENT

Medication: (dose/frequency/date) _____

Physiotherapy (type/frequency/date) _____

Please specify if done in clinic, hospital or home _____

Surgery Date (past): Day _____ Month _____ Year_____ Type: _____

Surgery Date (future): Day _____ Month _____ Year _____ Type: _____

5. RESULTS OF LABORATORY TESTS **Dates**

X-rays _____ ____ /____ /____ ____ /____ /____

Cat Scan/MRI _____ ____ /____ /____ ____ /____ /____

EMG Studies _____ ____ /____ /____ ____ /____ /____

Other _____ ____ /____ /____ ____ /____ /____

Is patient compliant with prescribed measures? Yes No

PLEASE ATTACH COPIES OF RELEVANT TEST RESULTS

6. RESTRICTIONS AND LIMITATIONS

Total hours

Functional capacity: SITTING 8 7 6 5 4 3 2 1 _____ Other

STANDING 8 7 6 5 4 3 2 1 _____ Other

WALKING 8 7 6 5 4 3 2 1 _____ Other

What specific factors, if any, interfere with the patient's ability to sit, stand or walk? _____

What devices might improve the patient's ability to sit, stand or walk? _____

Patient is able to:	Yes/no	Frequency	Duration
Drive			
Crouch			
Balance			
Bend			
Twist			
Stoop			
Kneel			
Squat			
Climb Stairs			
Reach at shoulder level			
Reach above shoulder level			
Reach below shoulder level			

7. PROGNOSIS

When do you anticipate the patient can return to work? ____ /____ /____

Own occupation: ____ /____ /____ Any occupation: ____ /____ /____ Or, if unable to determine, follow-up in _____ months

Is there any restriction you would like to see placed on patient's return to work? Yes No **Please comment** _____

Assessment and treatment are complicated by:

Significant emotional or behavioral disorder such as depression, anxiety, etc.

Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

Work-related issues **(please describe if known)** _____

Other **(please describe)** _____

Rehabilitation: a) Is patient a suitable candidate for medical rehabilitation services? Yes No

b) Is patient a suitable candidate for vocational rehabilitation? Yes No

c) If yes, **please specify** _____

Additional comments _____

Name of attending physician (please print) | Specialty | Telephone no. (including area code) ( ) —

Address (number, street, city, province, postal code) | Fax no. (including area code) ( ) —

Signature MD. | Date (day, month, year)

Submit to: **The Canada Life Assurance Company, Group Creditor Disability/Life Claims Department**
330 University Avenue, Toronto ON M5G 1R8
Telephone (416) 597-1440 Toll free no. 1-800-387-4492 Fax no. (416) 552-6557