Equitable Life of Canada®

Head Office
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Ontario N2J 4C7
TF 1-800-722-6615 **T** 519.886.5210 **F** 519.883.7406

Attending Physician's Disability Benefits Statement

(or at the insurer's option such other benefits as the insurer may wish to state)

Approved by CLHIA 1987

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

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

Phone Number (include area code)

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

Patient's Signature

Date *(day, month, year)*

Part 2: Attending Physician's Statement

1. **History**

a) Date symptoms first appeared or accident happened (day, month, year)

b) Date patient ceased work because of current condition (day, month, year)

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

d) Has patient ever had same or similar condition
❑ No ❑ Unknown ❑ Yes, state and describe

e) Is condition considered chronic
❑ No ❑ Yes, what precipitated absence from work

f) Names of other treating physicians or health care providers

2. **Diagnosis** *(including any complication)*

a. Primary

b. Additional conditions or complications which might affect duration of absence from work

c. Subjective symptoms

d. Objective signs (Please attach copies of current x-rays, EKGs, laboratory data and any relevant clinical findings that support your diagnosis)

3. **Physical Impairment**

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

4. **Mental/Nervous Impairment** *(if applicable)*

a) How does patient's mental or nervous impairment affect ability to work

b) Has there been psychiatric referral
❑ Yes ❑ No

c) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof
❑ Yes ❑ No

5. **Cardiac** *(if applicable)*

a. Functional capacity (American Heart Association)

❑ Class 1 (no limitation) ❑ Class 2 (slight limitation) ❑ Class 3 (marked limitation) ❑ Class 4 (complete limitation)

Please forward results of exercise stress tests, angiogram or other relevant documentation.

b. Blood pressure *(last visit)*

Systolic	Diastolic

6. **Treatment**

a. Date of first visit *(day, month, year)*

b. Date of latest visit *(day, month, year)*

c. Frequency of visits

❑ Weekly ❑ Monthly

❑ Other *(specify)*

d. Nature of treatment *(including surgery, physiotherapy and medications prescribed, if any)*

e. To your knowledge is patient following recommended treatment program

❑ Yes ❑ No, please comment

7. **Progress**

Has patient ❑ Recovered ❑ Improved ❑ Not improved ❑ Retrogressed

8. **Prognosis**

	Regular Occupation	**Any Other Occupation**
(a) Does disability prevent patient from performing?	❑ Yes ❑ No	❑ Yes ❑ No
(b) If "yes", please indicate when you expect patient will recover sufficiently to perform duties of:	❑ 1-3 months ❑ 3-6 months ❑ others, please specify ❑ Never	❑ 1-3 months ❑ 3-6 months ❑ others, please specify ❑ Never
(c) If "no", please indicate date patient was able to perform duties of:	Month Day Year	Month Day Year

9. **Rehabilitation**

a. Is patient a suitable candidate for further medical rehabilitation service *(ie. cardiopulmonary program, speech therapy, etc.)*

❑ No ❑ Yes

b. Would vocational counselling and/or retraining be recommended

❑ No ❑ Yes

c. Is patient suitable for trial employment

❑ No ❑ Yes, state date

(day, month, year)

10. **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 *(day, month, year)*