Equitable Life of Canada®

Head Office
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7
TF 1.800.265.4556 **T** 519.886.5210 **Fax** 1.888.505.4373
Email group-disability-claims@equitable.ca

DISABILITY BENEFITS ATTENDING PHYSICIAN'S STATEMENT CARDIAC

To allow us to make an assessment of your patient's claim, please answer all of the questions in full.

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 Number: | Certificate Number: | Claim Number:

Name | Date of Birth: DD / MM / YYYY

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

Phone Number (include area code)

I hereby authorize the release to Equitable Life of Canada® any information requested by Equitable Life of Canada in respect of this claim.

Patient's Signature | Date: DD / MM / YYYY

Part 2: Attending Physician's Statement

1. Diagnosis (please provide copies of all relevant clinical notes, test results and consultation reports on file)

Primary:

Secondary:

Date of first visit: DD / MM / YYYY

Date patient stopped working due to this condition: DD / MM / YYYY

Date of most recent visit: DD / MM / YYYY

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify)

Date of hospital in-patient admission: DD / MM / YYYY

Date of discharge: DD / MM / YYYY

Date of hospital out-patient admission: DD / MM / YYYY

Name of hospital:

Subjective symptoms (including severity/frequency/duration):

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2. Findings

☐ Chest pain of cardiac origin ☐ Syncope ☐ Fatigue ☐ Dyspnea due to vascular congestion or hypoxia

☐ Arrythmia ☐ Psychophysiologic ☐ Other (please specify)

BP readings over last 6 months (including dates)

Current height: Current weight: Weight loss/gain in last 6 months:

Current status? ☐ Stable ☐ Improving ☐ Regressing

3. Investigations (completed/scheduled) - please include copies of relevant test results.

If not provided, a decision on your patient's claim may be delayed.

EKG	DD / MM / YYYY
Echocardiogram	DD / MM / YYYY
Stress Test(s)	DD / MM / YYYY
Pulmonary Function Test	DD / MM / YYYY
Blood Test	DD / MM / YYYY
X-rays	DD / MM / YYYY
Angiogram	DD / MM / YYYY

What is the ejection fraction?

Does this increase with exercise? ☐ Yes ☐ No

Is patient following recommended treatment program? ☐ Yes ☐ No (please elaborate)

4(a). Treatment

Medications (dose/frequency/date prescribed):

Other treatment (please describe):

Surgery date (past)	DD / MM / YYYY	Type:
Surgery date (future)	DD / MM / YYYY	Type:

Other treating physicians:

Is patient compliant with prescribed measures? ☐ Yes ☐ No If no, please explain:

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4(b). Are there any complications prolonging your patient's recovery (please select and explain in the space provided below)?

- ☐ Significant emotional or behavioural disorder such as depression, anxiety, etc.
- ☐ Are objective findings consistent with your patient's complaints?
- ☐ Work-related issues (please describe if known)
- ☐ Substance abuse
- ☐ Other (please describe)

Has your patient been enrolled in a cardiac rehab program? ☐ Yes ☐ No

If yes, provide details:

5. Restrictions and limitations

Functional capacity: (Canadian Cardio-Vascular Society (CCS))

☐ Level 1 (no limitation) ☐ Level 2 (mild impairment) ☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

	Weight	Frequency	Duration
Lifting/Carrying	1-10 lbs. (0.5-4.5 kg) 11-20 lbs. (5.0-9.1 kg) 21-50 lbs. (9.5-22.7 kg)		
Pushing/Pulling	1-10 lbs. (0.5-4.5 kg) 11-20 lbs. (5.0-9.1 kg) 21-50 lbs. (9.5-22.7 kg)		
Standing	_____ hours		
Walking	_____ blocks		

Driver's license revoked? ☐ Yes ☐ No

6. What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation?

7. Return to work plans

Prognosis for return to work:

Expected date patient will return to their regular occupation:

Other factors affecting a return to work to their regular occupation or any occupation:

DD / MM / YYYY

If your patient is unable to return to their regular occupation at this time, please specify when and under what circumstances they could return to work to their regular occupation or another occupation.

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Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, physio, etc.)

☐ Yes ☐ No

Is patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No

If yes, specify. If no, why not?:

9. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

10. Have you completed other requests regarding your patient's current medical condition to other sources, i.e. other insurance providers, Canada Pension Plan, WSIB/WCB, etc.? ☐ Yes ☐ No

If so, please provide details:

Name of Physician (please print)

Specialty:

Telephone: Fax:

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

Physician's signature Date:

Please keep a copy of this form for your records. **Please do not use staples.** Send this completed form, along with any other pertinent documentation, to:

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Alternatively, you can **scan** and **email** the forms to group-disability-claims@equitable.ca.
Or **fax** your documents to 519 883 7406 or fax toll free to 1 888 505 4373

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