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 MUSCULOSKELETAL

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)

Primary:

Secondary:

Symptoms (including severity, frequency, duration)

Date symptoms first appeared:	DD / MM / YYYY	
Date patient stopped working due to this condition:	DD / MM / YYYY	
Date of first visit for treatment or consultation:	DD / MM / YYYY	

Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe:

Is condition a result of an injury due to an accident? ☐ Yes ☐ No ☐ Unknown

If yes, please describe:

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

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

If yes, have you submitted Workers' Compensation forms? ☐ Yes ☐ No ☐ Unknown

Date of most recent visit: DD / MM / YYYY

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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:		
Have any referrals been made to specialists or other treatment providers?	☐ Yes ☐ No ☐ Unknown	

If yes, please provide names and addresses of doctors referred to and appointment dates.

2. Please outline all objective studies performed/scheduled and attach copies of all investigative test results, including x-rays, laboratory data, CT scans, etc. If not provided, you may be delaying a decision on your patient's claim.
Medications (dose, frequency, date prescribed)

3. Please indicate the nature and severity of the patient's symptoms and signs.

	Please specify location(s)	Physical Findings (eg Range of Motion)	Severe	Moderate	Mild	Absent
Pain			☐	☐	☐	☐
Deformity			☐	☐	☐	☐
Muscle Spasm			☐	☐	☐	☐
Muscle Atrophy			☐	☐	☐	☐
Loss of Tendon Reflexes			☐	☐	☐	☐
Sensory Change			☐	☐	☐	☐
Motor Deficit			☐	☐	☐	☐
Straight Leg Raising Limitation			☐	☐	☐	☐
Range of Motion Limitation			☐	☐	☐	☐
Other (specify)			☐	☐	☐	☐

If Arthritic Condition: ☐ In Remission ☐ Seasonally Active ☐ Continuously Active ☐ Intermittently Active ☐ Stable ☐ Progressive

If Fracture ☐ Closed ☐ Open ☐ Compound ☐ Comminuted

4(a) Treatment

Medications (dose/frequency/date prescribed):		
Physiotherapy (type, frequency, dates):		
Surgery date (past)	DD / MM / YYYY	Type:
Surgery date (future)	DD / MM / YYYY	Type:

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Other treatment:

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

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

☐ Significant emotional or behavioural diagnoses such as depression, anxiety, etc.

☐ Are your objective findings consistent with your patient's complaints?

☐ Work-related issues (please describe if known)

☐ Substance abuse

☐ Other (please describe)

5. Restrictions and limitations

Lifting	☐ Under 10 pounds	☐ 10-20 pounds	☐ 20-50 pounds	☐ Over 50 pounds
Carrying	☐ Under 10 pounds	☐ 10-20 pounds	☐ 20-50 pounds	☐ Over 50 pounds
Reaching	☐ Above shoulder height	☐ At shoulder height	☐ Below shoulder height	

Sitting	hours	Overhead Lifting	hours
Standing	hours	Pushing/Pulling	hours
Walking	hours	Gripping	hours
Pinching	hours		

6. Prognosis/Return to work plans

Prognosis for recovery:

Expected date patient will return to their regular occupation:

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.

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

7. Rehabilitation

Is patient a suitable candidate for medical rehabilitation services (physio/OT/massage/acupuncture)? ☐ Yes ☐ No

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

If yes to either of the above, please specify. If no, why not?

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8. 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?

9. 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: DD / MM / YYYY

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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