SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

ATTENDING PHYSICIAN'S STATEMENT - GENERAL

PART 1 - EMPLOYEE (MEMBER) TO COMPLETE

Name (Last, First, Middle Initial) | Phone Number (include area code)

Address (Street Number and Name) | Apartment or Suite | City

Province | Country | Postal/Zip Code

Employer's Name | Plan/Policy ID | Certificate Number

Last Date Worked (YYYY/MM/DD) | Date Returned to Work or Expected Return to Work Date (YYYY/MM/DD)

Height | Weight | Dominant Hand ☐ Left ☐ Right

Name of Medication	Start Date (YYYY/MM/DD)	Last Date of Change (YYYY/MM/DD)	Current Dosage	Frequency

I authorize the release of personal information and personal health information in my file by the healthcare provider listed on this form to Saskatchewan Blue Cross, Blue Cross Life Insurance Company of Canada and/or its authorized agents for the purposes of determining eligibility for coverage, underwriting, claims adjudication and payment, administering products and services, audit and investigation. This personal information and personal health information includes, but it not limited to, copies of all consultation reports, my medical history, clinical notes, test results and hospital records. Medical and health information excludes genetic test results.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853.

Employee (Member) Signature | Date of Consent (YYYY/MM/DD)

PART 2 - PHYSICIAN TO COMPLETE

I am the: ☐ Family Physician ☐ Consulting Specialist ☐ Other (Please Specify) _____

PLEASE NOTE: Any charges associated with completing this form are the responsibility of your patient.

PLEASE COMPLETE THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE.

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DIAGNOSIS

Primary:

Secondary and/or Complications:

If Childbirth _____ ☐ Expected ☐ Actual
Delivery Date (YYYY/MM/DD)

Delivery Method: ☐ Vaginal ☐ C-Section

Is this condition due to: Occupational illness/injury: ☐ Yes ☐ No Auto accident: ☐ Yes ☐ No

If yes, date of event: _____ (YYYY/MM/DD) If yes, date of event: _____ (YYYY/MM/DD)

Have you completed any other disability claim forms recently for this patient? ☐ Yes ☐ No

If yes, please indicate requester (other insurance company, CPP, QPP, Workers Compensation Board, etc.):

Date of first visit to you pertaining to this condition (YYYY/MM/DD)

First Date of work absence due to condition (YYYY/MM/DD)

TREATMENT

Please list any other treatments, therapies other than medications.

Frequency of visits ☐ Weekly ☐ Monthly ☐ Other (Specify)

Date of last visit (YYYY/MM/DD)

Treatment Provider

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Please elaborate:

RESPONSE TO TREATMENT

Please describe the response to treatment to date: ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

Are there any plans to change or augment the current treatment program? ☐ Yes ☐ No

If so, please explain:

HOSPITALIZATION

Is/was the patient hospitalized? ☐ Yes ☐ No Is future hospitalization planned? ☐ Yes ☐ No

Date of admittance (YYYY/MM/DD)	Date of discharge (YYYY/MM/DD)	Institution name

If surgery was/will be performed, please provide date(s) and description of surgery:

Date of admittance (YYYY/MM/DD)	Description

INVESTIGATIONS

PLEASE ATTACH COPIES OF ALL RELEVANT

- Test results/investigations - **do not provide genetic test results.** If test results are not attached, we will interpret this as tests were not performed.
- Consultation reports

Are tests/investigations pending? ☐ Yes ☐ No (if Yes, please indicate below)

Date (YYYY/MM/DD)	Description

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future? ☐ Yes ☐ No
(If Yes, please indicate below)

Name of Specialist	Specialty	Date (YYYY/MM/DD)

CLINICAL FINDINGS AND OBSERVATIONS

Please describe the patient's symptoms including history, severity, and frequency

How have the patient's symptoms evolved to date? ☐ Improved ☐ No Change ☐ Retrogressed

Please explain:

FUNCTIONAL/COGNITIVE RESTRICTIONS AND LIMITATIONS

Restrictions and Limitations

Functional Capacity (Duration in hours)

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?

		Continuously	Frequently	Occasionally	Patient is able to	Frequency/ Duration
Lift/Carry	Less than 10lb/5kg				Drive	
	More than 10lb/5kg				Crouch	
	More than 20lb/10kg				Balance	
	More than 50lb/25kg				Bend/Stoop	
Push/Pull	Less than 10lb/5kg				Twist	
	More than 10lb/5kg				Kneel/Squal	
	More than 20lb/10kg				Climb Stairs	
	More than 50lb/25kg				Reach at shoulder level	
					Reach above shoulders	
					Reach below shoulders	

Please indicate cognitive tasks impacted by the medical condition

If there is no cognitive impairment, please skip this section.

Please indicate your patient's capacity to carry out each of the activities including a detailed description of the limitation if one exists AND the supporting clinical observations or formal testing results that lead to that conclusion.

Activity	Current Ability	Summarize the clinical observations and/or objective testing results supporting the limitation.
Understand, remember and carry out instruction	☐ No Impairment ☐ Impairment Describe:	
Maintain attention and concentration for extended periods	☐ No Impairment ☐ Impairment Describe:	
Perform activities within a schedule	☐ No Impairment ☐ Impairment Describe:	
Working under pressure or deadlines	☐ No Impairment ☐ Impairment Describe:	
Juggling tasks and prioritizing work	☐ No Impairment ☐ Impairment Describe:	
Sustaining an ordinary routine without supervision	☐ No Impairment ☐ Impairment Describe:	
Making simple decisions or solving straight forward problems	☐ No Impairment ☐ Impairment Describe:	
Solving complex problems	☐ No Impairment ☐ Impairment Describe:	

Activity	Current Ability	Summarize the clinical observations and/or objective testing results supporting the limitation.
Working alone or independently	☐ No Impairment ☐ Impairment Describe:	
Working in a team or with others	☐ No Impairment ☐ Impairment Describe:	
Interacting with the general public or customers	☐ No Impairment ☐ Impairment Describe:	
Responding to frequent changes in the environment or tasks	☐ No Impairment ☐ Impairment Describe:	
Traveling in unfamiliar places or using public transportation	☐ No Impairment ☐ Impairment Describe:	
Other:	☐ No Impairment ☐ Impairment Describe:	

Has any license held by the patient been restricted or revoked as a result of this condition ☐ Yes ☐ No

If yes, as of when (YYYY/MM/DD) Type of license
For how long?

Do you have concerns about the patient's ability to manage own affairs? ☐ Yes ☐ No

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals? ☐ Yes ☐ No

Factors Affecting Recovery

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

Has the patient previously had similar condition? ☐ Yes ☐ No

If Yes, please specify date of initial onset (YYYY/MM/DD): _____

ESTIMATED TIME FOR RECOVERY

Patient Progress:

☐ None ☐ Regressed ☐ Minimal Improvement ☐ Significant Improvement ☐ Plateaued ☐ Resolved

Patient Prognosis ☐ Poor ☐ Good

Expected duration of recovery period (YYYY/MM/DD): _____

In your opinion, is the patient a suitable candidate for medical or functional rehabilitation (i.e., conditioning program, counseling, etc.)?

☐ Yes ☐ No

Explain why:

In your opinion, is the patient a suitable candidate for a work re-entry program (i.e., ease back, modified duties, gradual return to work, etc.)?

☐ Yes ☐ No

Explain why:

Any additional information or details that may have a significant impact on patient's recovery from this condition?

NOTICE TO PHYSICIAN

The information in this statement will be kept in a life, health or disability benefit file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

Physician's Name (please print)	Certified Specialty	
Address (Street, City, Province, Postal Code)		
Telephone Number (include area code)	Fax Number (include area code)	
Signature	Date Signed (YYYY/MM/DD)	Physician's Stamp