New Nouveau Brunswick

ATTENDING PHYSICIAN'S STATEMENT - APPLICATION FOR BENEFITS

☐ **LONG TERM DISABILITY (LTD) BENEFITS**
☐ **CONTINUATION OF BENEFITS DURING DISABILITY (WAIVER OF PREMIUM)**

INSTRUCTIONS:

1. Please Print.
2. Part I to be completed by patient.
3. Remainder to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

******ATTACH COPIES OF ALL CLINIC NOTES, TEST RESULTS, CONSULTATION REPORTS AND HOSPITAL DISCHARGE SUMMARIES******

PART I: PATIENT AUTHORIZATION: (Allowing your Physician to complete and submit this form)

Name: _____ Date of Birth (DD/MM/YYYY): _____
Last First Initial

Social Insurance Number: _____

I hereby authorize the release of any information herein requested by my insurer or its agents.

Signature: _____ Date (DD/MM/YYYY): _____

PART II: HISTORY OF PRESENT CONDITION(S)

1. If the condition is related to pregnancy, indicate the date or expected date of delivery (DD/MM/YYYY): _____
   (attach prenatal clinical notes)
2. Is the condition due to injury or sickness arising out of the patient's employment? ○ Yes ○ No ○ Unknown
   Have Worksafe New Brunswick forms been completed? ○ Yes ○ No ○ Unknown
3. a) Primary Diagnosis: Scale: DSM ( ) Grade ( )
   Class ( ) Stage ( )
   b) Secondary Diagnosis: Scale: DSM ( ) Grade ( )
   Class ( ) Stage ( )
   c) Date symptoms first appeared or accident happened (DD/MM/YYYY): _____
   d) Initial date of examination for this condition (DD/MM/YYYY): _____
   e) Patient was unable to work as of (DD/MM/YYYY): _____
   f) Symptoms (include severity and frequency): _____
   _____
   g) What aspects of their condition affects the patient's ability to work?: _____

PART III: FACTORS AFFECTING RECOVERY

☐ Addiction _____
☐ Diet _____
☐ Work Environment _____
☐ Home Environment _____
☐ Social and Family Issues _____
☐ Family History of Present Condition _____
☐ Current: Height: _____ Weight: _____ Right or left hand dominant: _____
☐ Past Medical History _____
_____
_____

Has the patient previously had a similar condition? ○ Yes ○ No If yes, please specify date of initial onset. _____

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Name of Patient: _____

PART IV: MANAGEMENT PLAN FOR THE CURRENT CONDITION

	STARTED DD	MM	YYYY
Hospitalization date(s) - **include Admission/Discharge Summaries**			
Surgery date(s) and type - **include Operative Report(s)**			

Medication Name	Dosage	Date Prescribed	
			Discontinued? ○ Yes ○ No
			Discontinued? ○ Yes ○ No
			Discontinued? ○ Yes ○ No

	Name	Specialty	DD	MM	YYYY
Specialist					
Additional Planned Testing					
Therapist					
Other					

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

PART V: CARDIAC CONDITION - COMPLETE IF APPLICABLE ☐ N/A

1. Clinical Findings:

☐ Chest pain ☐ Syncope ☐ Fatigue ☐ Dyspnea due to vascular congestion/hypoxia ☐ Psychophysiology

☐ Blood pressure readings (at least three) at onset of current condition: _____

☐ Other, please specify: _____

2. Restrictions and Limitations

Functional Capacity: (Canadian Cardio-vascular Society (CCS))
○ Level 1 (no limitations) ○ Level 2 (mild impairment) ○ Level 3 (moderate impairment) ○ Level 4 (severe impairment)

3. Laboratory / Diagnostic Testing - **(attach copies of all relevant test results)**

PART VI: PSYCHIATRIC CONDITION - COMPLETE IF APPLICABLE ☐ N/A

1. **Diagnosis (Please use DSM IV criteria)**

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V Current GAF Global Assessment of Functioning Score _____

Highest GAF Score in Past Year _____

Lowest GAF Score in Past Year _____

Supporting Data

Please describe the symptoms (severity and frequency) and medical or psychological test results that support each axis of your diagnosis.

2. Have you referred your patient to:

Psychologist? ○ Yes ○ No If Yes, please specify date of referral (DD/MM/YYYY): _____ Goal _____

Psychiatrist? ○ Yes ○ No If Yes, please specify date of referral (DD/MM/YYYY): _____ Goal _____

Name of Patient: _____

PART VII: MUSCULOSKELETAL CONDITION - COMPLETE IF APPLICABLE ☐ N/A

1. Symptoms (include severity and frequency):

Area: ☐ Cervical ☐ Thoracic ☐ Lumbosacral ☐ Other _____

Type: ☐ Stiffness ☐ Paresthesias ☐ Impaired range of motion ☐ Muscle spasms

2. Clinical Findings (attach copies of X-rays, CT Scan/MRI, Blood Work, etc.):

_____

☐ Neurological deficits:

Power	○ Yes ○ No	If yes, degree:	_____
Sensory loss	○ Yes ○ No	If yes, degree:	_____
Reflexes	○ Yes ○ No	If yes, degree:	_____

PART VIII: RESTRICTIONS AND LIMITATIONS - COMPLETE IF APPLICABLE

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? _____

Lift / Carry	Less than 10 lbs / 5kg	○ Continuously	○ Frequently	○ Occasionally
	More than 10 lbs / 5kg	○ Continuously	○ Frequently	○ Occasionally
	More than 20 lbs / 10kg	○ Continuously	○ Frequently	○ Occasionally
	More than 50 lbs / 25kg	○ Continuously	○ Frequently	○ Occasionally
Push / Pull	Less than 10 lbs / 5kg	○ Continuously	○ Frequently	○ Occasionally
	More than 10 lbs / 5kg	○ Continuously	○ Frequently	○ Occasionally
	More than 20 lbs / 10kg	○ Continuously	○ Frequently	○ Occasionally
	More than 50 lbs / 25kg	○ Continuously	○ Frequently	○ Occasionally

Patient is able to:	Frequency / Duration	Patient is able to:	Frequency / Duration
Drive		Kneel / Squat	
Crouch		Climb Stairs	
Balance		Reach at shoulder level	
Bend / Stoop		Reach above shoulders	
Twist		Reach below shoulders	

PART IX: TO BE COMPLETED FOR ALL CONDITIONS - ESTIMATED TIME FOR RECOVERY / REHABILITATION PLANNING

Patient Progress: ○ None ○ Regressed ○ Minimal Improvement ○ Significant Improvement ○ Plateaued ○ Resolved

Prognosis: ○ Poor ○ Good

Expected duration of recovery period: _____

In your opinion, is the patient a suitable candidate for medical or functional rehabilitation (i.e. conditioning program, counselling, etc.)?
○ Yes ○ No Please elaborate on your opinion:

In your opinion, is the patient a suitable candidate for a work re-entry program (i.e. modified duties, gradual return to work, etc.)?
○ Yes ○ No Please elaborate on your opinion:

If unable to determine, follow up in _____ weeks or _____ months

What is being done (or is needed) in the following areas to help your patient return to a productive lifestyle? (Check all appropriate boxes)

☐ Physical Conditioning ☐ Stress Managment / Coping Skills ☐ Social Confidence Building ☐ Vocational Counselling

☐ Other _____

Please specify any additional information or details that may have a significant impact on the patient's recovery from this condition:

PART X: ATTENDING PHYSICIAN'S STATEMENT

Name of Attending Physician (please print): _____

Address:

Tel.No.: _____ Fax No.: _____

Signature: _____ Date: _____

Complete and return to: **Medavie Blue Cross**
P.O. Box 220, 644 Main Street, Moncton, NB E1C 8L3
Phone Toll Free in Canada: 1-877-347-5055 Fax: 1-800-644-1722 absence@medavie.ca

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