New Nouveau Brunswick

ATTENDING PHYSICIAN'S STATEMENT – APPLICATION FOR BENEFITS

☐ **LONG TERM DISABILITY (LTD) BENEFITS**

☐ **CONTINUATION OF BENEFITS DURING DISABILITY (WAIVER OF PREMIUM)**

25-1738(2/17)

Instructions:
1. Please print
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.

Please note:
The patient is responsible for the securing of this form and any charge for its completion.

PART 1 - PATIENT AUTHORIZATION

Name: _____ Age: _____
(First) (Last)

Social Insurance Number: _____ - _____ - _____ Tel. No.: _____

I hereby authorize the attending/consulting physician and/or health institution/provider to release any information in respect of this claim to my benefits' adjudicators and/or policyholder. I understand that any charges for having this form completed are my responsibility.

Signature: _____ Date _____

PART 2 - ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis

Primary: _____ Symptoms _____

Secondary: _____ Symptoms _____

Other contributing factors/complications: _____

2. History

Symptoms began or accident happened on: D M Y

Date of first visit for current condition: D M Y

Work ceased due to illness or injury on: D M Y

Is this a work-related illness/injury? ☐ Yes ☐ No ☐ Unknown

Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and provide details:

Relevant medical history? Please explain and give approximate dates. _____

If condition is related to pregnancy, indicate date or expected date of delivery: D M Y

3. Clinical Findings/Investigations

Date of most recent examination of patient: D M Y

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Cardiac: _____ (if applicable) ☐ Class 1 no limitation ☐ Class 2 slight limitation ☐ Class 3 marked limitation ☐ Class 4 complete limitation

ATTACH ALL COPIES OF CURRENT X-RAYS, EKGS, LABORATORY DATA, CONSULTATION REPORTS, HOSPITAL DISCHARGE SUMMARIES, CLINICAL NOTES ETC.

Any other investigations planned? ☐ Yes ☐ No If yes, state when and type of investigation _____

Is patient being treated or referred to other physician(s)/specialist(s)? ☐ Yes ☐ No If yes, please complete the following:

Physician's Name & Specialty	Date Patient last seen and next date to be seen

4. General Impression (Describe appearance, development, nutrition, posture, gait, distress, mental alertness, apparent age, etc.)

5. Treatment - Frequency of patient visits: _____ Date of last visit: D M Y

Medications? ☐ Yes ☐ No If yes, please provide details below.

Current medications	Dosage

Surgery? ☐ Yes ☐ No If yes, please provide details below.

Type of Surgery	Date Performed or Date Planned

Hospitalization? ☐ Yes ☐ No If yes, please provide details below.

Admission Date	Discharge Date	Facility	Reason

Therapy? ☐ Yes ☐ No If yes, please provide details below.

Type (e.g. physio, psycho, chiro)	Name of Practitioner

Is the patient receiving or in need of treatment for the use of alcohol or drugs? ☐ Yes ☐ No

Any other treatment or future plans for treatment? (Please specify with dates.) _____

Summarize patient's response to treatment:

Is patient following recommended treatment? ☐ Yes ☐ No (Please elaborate.)

6. Functional Capability - If condition is psychiatric, provide multiaxial assessment, if available.

Is patient: ☐ ambulatory ☐ house confined ☐ bed confined ☐ hospital confined? Please check box that best describes patient's level of function:

- ☐ No limitation of functional capacity; capable of normal activity.
- ☐ Minimal limitation of functional capacity; capable of moderate activity.
- ☐ Medium limitation of functional capacity; capable of light activity.
- ☐ Severe limitation of functional capacity; incapable of minimal activity.

Please provide details of any functional limitations/restrictions and provide examples of activity patient is capable of doing:

7. Prognosis & Recovery Factors

Prognosis and timeframe for medical recovery:

Other factors affecting recovery? Please explain.

Please indicate factors to be considered regarding a return to work plan:

8. Remarks

Please provide any additional information or details that may be helpful.

Name of Attending Physician
(Please print)

Address: Tel.No. ( ) -

Fax No. ( ) -

Signature: Date:

Complete and return to: **Medavie Blue Cross**
644 Main Street, Moncton, NB E1C 8L3 **TEL: 1-877-849-8509**
ATTN: Case Management Services **FAX: 1-800-644-1722**