# ATTENDING PHYSICIAN'S STATEMENT – APPLICATION FOR DISABILITY PENSION

☐ **NB TEACHERS' PENSION PLAN**

☐ ***PROVINCIAL COURT ACT***
***PROVINCIAL COURT JUDGES' PENSION ACT***

(02/2024)

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, Case Management Services**
**644 rue Main Street, PO Box 220, Moncton, NB E1C 8L3**
**Telephone: 506 867-4305 Toll free: 1 877 347 5055**