SASKATCHEWAN
BLUE CROSS®

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ATTENDING PHYSICIAN STATEMENT
CARDIAC

Instructions

1. Please print.
2. Part I to be completed by patient.
3. Part II–VI to be completed by physician.
4. Any fee for completing this form is the patient's responsibility.

PART I: PATIENT AUTHORIZATION

Name ______________________________ Date of Birth ____ | ____ | ____
Last First Initial YYYY MM DD

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

Signature ______________________________ Date ______________

PART II: ATTENDING PHYSICIAN

Name ______________________________ Specialty ______________

Address ______________________________

Telephone ______________ Fax ______________ Email ______________

Part III: HISTORY OF PRESENT CONDITION(S)

1. Specific cardiac diagnosis ______________________________
2. Secondary diagnosis ______________________________
3. Date symptoms first appeared ____ | ____ | ____ (YYYY MM DD)
4. Initial examination date ____ | ____ | ____ (YYYY MM DD)
5. Date patient ceased working due to this condition ____ | ____ | ____ (YYYY MM DD)
6. Symptoms (include severity & frequency) ______________________________
7. Clinical findings:
   - ☐ Chest pain of cardiac origin
   - ☐ Syncope
   - ☐ Fatigue
   - ☐ Dyspnea due to vascular congestion/hypoxia
   - ☐ Psychophysiology
   - ☐ Blood pressure readings (at least three) at onset of current condition ______________
   - ☐ Other (please specify) ______________
8. Laboratory/Diagnostic (attach copies of all relevant test results)

Laboratory/Diagnostic Testing	YYYY	MM	DD	YYYY	MM	DD
EKG						
Echocardiogram						
Stress Thallium Test						
Pulmonary Function Test						
Blood Test						
X-rays						
Other						

9. Current height ______________ weight ______________

Part IV: 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 a similar condition? ☐ Yes ☐ No If yes, specify date of initial onset ______________

PART V: MANAGEMENT PLAN FOR THE CURRENT CONDITION

DATE (YYYY | MM | DD)

☐ Frequency of visits ____________ | |

☐ Date of most recent visit ____________ | |

☐ Date of re-evaluation ____________ | |

☐ Hospitalization dates - include admission/discharge summaries

____________ | |

____________ | |

____________ | |

____________ | |

☐ Surgery date(s) and type(s) - include operative report(s)

____________ | |

____________ | |

____________ | |

☐ Medication – include dosage

____________ | |

____________ | |

____________ | |

____________ | |

Name of Other Health Care Providers **Specialty**

☐ Other specialists ____________ ____________ | |

☐ Counsellor ____________ ____________ | |

☐ Therapist ____________ ____________ | |

Is the patient following recommended treatment program? ☐ Yes ☐ No If no, explain circumstances ____________

____

____

PART VI: ESTIMATED TIME FOR RECOVERY

1. Current Status ☐ Stable ☐ Improving ☐ Regressing
2. Restrictions and Limitations

Functional capacity per Canadian Cardiovascular Society (CCS)

☐ Level 1 (no limitations) ☐ Level 2 (mild impairment) ☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

	Weight	Frequency	Duration
Lifting/ Carrying	1-10 lb (0.5-4.5 kg)		
	11-20 lb (5-9.1 kg)		
	21-50 lb (9.5-22.7 kg)		
Pushing/ Pulling	1-10 lb (0.5-4.5 kg)		
	11-20 lb (5-9.1 kg)		
	21-50 lb (9.5-22.7 kg)		
Standing			
Walking			
Other			

What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation?

How does this affect the patient's ability to perform activities of daily living?

3. 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 Provide comments and recommendations. ____________

____

____

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

____

____

____

Signature ____________ Date ____________

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