

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 <input type="checkbox"/> Left <input type="checkbox"/> 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I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.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-USEBLUE*.

Employee (Member) Signature	Date of Consent (YYYY/MM/DD)
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PART 2 - PHYSICIAN TO COMPLETE

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

PLEASE COMPLETE THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE.



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: _____ If yes, date of event: _____
(YYYY/MM/DD) (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/Squat	
	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	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Maintain attention and concentration for extended periods	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Perform activities within a schedule	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Working under pressure or deadlines	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Juggling tasks and prioritizing work	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Sustaining an ordinary routine without supervision	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Making simple decisions or solving straight forward problems	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Solving complex problems	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	

Activity	Current Ability	Summarize the clinical observations and/or objective testing results supporting the limitation.
Working alone or independently	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Working in a team or with others	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Interacting with the general public or customers	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Responding to frequent changes in the environment or tasks	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Traveling in unfamiliar places or using public transportation	<input type="checkbox"/> No Impairment <input type="checkbox"/> Impairment Describe:	
Other:	<input type="checkbox"/> No Impairment <input type="checkbox"/> 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) For how long? Type of license

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)		