Manulife

Colleges, Universities and Institutes Benefits Consortium

Group Benefits
Attending Physician's Statement
Abilities Management Access

The purpose of this Statement is to assist Manulife in confirming the anticipated duration of your patient's absence, determining functional abilities and assessing fitness to return to work. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife to make this decision. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE, OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CASE. ***PLEASE KEEP A COPY FOR YOUR RECORDS.***

Manulife recognizes and respects the role of the treating physician in the safe and timely return to work of their patients as outlined in the Canadian Medical Association Policy Statement.

Return completed forms: **Email:** Vancouver_group_disability_claims@manulife.ca
Fax: 1-866-413-3582
Canada Post: **Manulife Case Management Centre**
1095 West Pender Street
PO BOX 48198, VANCOUVER BC V7X 1N8

1 Patient authorization

Plan contract number	Employee certificate number	Division
0039941		

Name of patient (last, first, middle initial)

Address (number, street and apt.)

City	Province	Postal code

Date of birth (dd/mmm/yyyy)	Height	Weight

I hereby authorize the release to Manulife of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. **I understand that I am responsible for any fees related to the completion of this form.**

Patient's signature	Date (dd/mmm/yyyy)

2 Attending Physician Statement

A. History

When did symptoms first appear or accident happen? — Date (dd/mmm/yyyy)

What date did patient cease work because of illness/injury? — Date (dd/mmm/yyyy)

Has patient ever had the same or a similar condition? ◯ Yes ◯ No

If *yes*, state when and describe.

Is condition due to injury or sickness arising out of patient's employment? ◯ Yes ◯ No ◯ Unknown

Is a claim being submitted to any type of worker's compensation board? ◯ Yes ◯ No

Has the patient been confined in a hospital?
If available please include admission and discharge summaries. ◯ Yes ◯ No

If *yes*	Admission date (dd/mmm/yyyy)	Date (dd/mmm/yyyy)
	Admission date (dd/mmm/yyyy)	Date (dd/mmm/yyyy)
	Admission date (dd/mmm/yyyy)	Date (dd/mmm/yyyy)

Name, specialty and address of other treating physician(s)

Name	Specialty	Address

B. Diagnosis

a) Primary

b) List any additional conditions or complications

c) Subjective symptoms

d) DSM IV Axis 1 (If psychiatric diagnosis)

What is the current GAF?

Remarks

e) **Please include copies of the following documentation in support of the stated diagnosis: consultation notes, test/investigation report(s), psychological testing report(s), operative report(s), hospital admission and discharge summary(ies).**

If your patient is/was pregnant, please provide the expected/actual delivery date. (dd/mmm/yyyy)

3 Treatment

Frequency of visits

- Weekly
- Monthly
- Other (specify)

Date of first visit (dd/mmm/yyyy)

Date of last visit (dd/mmm/yyyy)

Date of all visits between first and last visit (dd/mmm/yyyy)

Nature of treatment (including surgery, physiotherapy, psychotherapy and medications prescribed and dosages)

To your knowledge is patient following the recommended treatment program? ◯ Yes ◯ No

Is there potential for future improvement? ◯ Yes ◯ No

If *no*, please comment.

Have you recommended that your patient's driver's licence be revoked? ◯ Yes ◯ No

4 Cardiac (if applicable)

a) Functional capacity (American Heart Association)

- ◯ Class 1 - Ordinary activity does not cause symptoms of undue fatigue, palpitations, dyspnea, or anginal pain.
- ◯ Class 2 - Greater than ordinary physical activity results in symptoms.
- ◯ Class 3 - Ordinary physical activity results in symptoms.
- ◯ Class 4 - Symptoms at rest, and worse with any physical activity.

b) Blood pressure (last 3 visits)

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

5 Physician authorization

Attending physician (please print)

Certified specialist

Address (number, street, suite, city, province, postal code)

Telephone number Ext.

Fax number

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. The information in this statement will be kept in a group life, health, and/or disability case file with Manulife and might be accessible by the employee or third parties to whom access has been granted or those authorized by law. By providing the information **I consent** to such unedited release of any information contained herein.

Signature

Date signed (dd/mmm/yyyy)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM, IN THE PROVINCES WHERE APPLICABLE.

PRINT