RBC Insurance®

ATTENDING PHYSICIAN SUPPLEMENTARY STATEMENT

PATIENT'S INFORMATION

Name: _____
Last First Middle

Date of Birth: _____ _____ _____ _____
(MM/DD/YYYY) Height (in/cm) Weight (lb/kg) Policy No(s)

DIAGNOSIS

1. a) Primary diagnosis: (if psychiatric, indicate the DSM-IV, including all axes/if cardiac, include Cardiac Class and Blood Pressure at last visit)

_____

_____

b) Secondary diagnosis: (including complications)

_____

_____

c) Current symptoms which prevent or limit the patient's ability to work:

_____

_____

d) Objective findings. Include the name of objective tests, dates performed and the results:

_____

_____

e) If condition is due to pregnancy, what is the expected date of delivery? _____ (MM/DD/YYYY)

TREATMENT

2. Date of latest visit: _____ (MM/DD/YYYY) Frequency of visits: ❑ Weekly ❑ Monthly ❑ Other (specify) _____

3. Has the patient been hospitalized? ❑ Yes ❑ No If "Yes," indicate:

_____ _____
Name of hospital(s) Dates(s) confined: from (MM/DD/YYYY) to (MM/DD/YYYY)

_____ _____
Name of hospital(s) Dates(s) confined: from (MM/DD/YYYY) to (MM/DD/YYYY)

4. Has the patient had surgery in relation to this condition? ❑ Yes ❑ No If "Yes," Indicate:

_____ _____
Name of procedure(s) Date(s) performed (MM/DD/YYYY)

5 Current medication(s):

Name of medication	Dosage	Date prescribed (MM/DD/YYYY)

6. Briefly summarize your treatment and return to work plan: _____

_____

7. Is the patient non-compliant in any way with the recommended treatment plan? ❑ Yes ❑ No If "Yes," explain: _____

_____

8. Are you aware of any personal, workplace or treatment factors of a primarily non-medical nature impacting the patient's ability to resume work? ❑ Yes ❑ No If "Yes," explain: _____

_____

9. a) What are the patient's activity restrictions (what the patient SHOULD NOT do)? _____

b) What are the patient's activity limitations (what the patient CANNOT do)? _____

c) Please list which specific occupational duties the patient is limited or prevented from performing, and by which specific symptom:

10. a) Have you been actively supervising this patient's care? ❑ Yes ❑ No If "No," explain: _____

b) What treatment has the patient received since the last statement, and by whom? _____

c) Does the patient perceive that the treatment has helped, or is likely to be helpful? _____

11. What is your prognosis?

a) ❑ Recovery without impairment (loss of function) Number of weeks _____

b) ❑ Stabilization with continuing impairment Number of weeks _____

c) ❑ Permanent impairment

d) Comments: _____

12. Is the patient a suitable candidate for trial employment? For his/her occupation ❑ Yes ❑ No For any other work ❑ Yes ❑ No

Please provide comments or further details that you feel are relevant to the ability of the patient to return to work: _____

We would appreciate it if you would please attach a copy of your recent medical records, including consultation reports, test results and hospital summaries.

SIGNATURE

NOTE: The Patient is responsible for securing completion of this form and any charge for its completion.

X _____ _____ _____

Signature | Date (MM/DD/YYYY) | Degree and Specialty

_____ ❑ Primary Care ❑ Consultant

Physician's Name

_____

Address

_____

City | Province | Postal Code

Telephone No. ( ) _____ Fax No. ( ) _____

MAIL THE COMPLETED FORM TO:

RBC Life Insurance Company, Life and Health Claims Department

P.O. Box 4435, Station A, Toronto, ON M5W 5Y8 ***or fax to*:** 1-800-714-8861

If you have any questions, call toll free 1-877-519-9501 or 416-643-4700