RBC Life Insurance Company
4435 Stn A
Toronto, ON M5W 5Y8

ATTENDING PHYSICIANS HOME CARE CLAIMS STATEMENT

PATIENT NAME _____ POLICY NUMBER _____

I hereby authorize the release to my insurer any information requested with respect of this claim.

DATE _____ SIGNATURE OF PATIENT _____

PHYSICIAN'S STATEMENT

This form has been specifically designed with the physician in mind. By being comprehensive, it will hopefully reduce the physician;s administrative workload. Please complete the sections relating to your patient and stroke out the non-applicable areas. In order to help the claimant, sufficient details of History, Investigation, Findings and Treatment are essential. This form may be mailed directly to the insurer or given to the patient at the physician's discretion.

HISTORY

(a) When did symptoms first appear or accident happen? _____ Month _____Day, _____Year

(a) Date home care commenced (if applicable) _____ Month _____ Day, _____ Year

(c) Type of care required and frequency of visits by the Provider _____

(d) Date home care terminated _____ Month _____Day, _____ Year

(e) Full names of other treating physicians _____

_____

DIAGNOSIS

(a) Primary

(b) Date of Diagnosis _____

(c) Secondary (if applicable)

(d) Date of Diagnosis _____

(e) Subjective Symptoms

(f) Objective findings (including results of current X-rays, E.K.G.s or any other special tests)

TREATMENT

(a) Date of first treatment

(b) Date of latest visit

(c) Is patient following recommended treatment program? o Yes o No

(d) Dates of all treatment

(e) Frequency: o Weekly o Monthly o Other (specify) _____

TYPE OF TREATMENT

(a) Medications Dosages

(b) Describe Therapy and projected duration of treatment program

(c) Type of surgery

(d) Date of surgery (if applicable)

PHYSICAL IMPAIRMENT

Is patient ο Ambulatory ο Bed confined ο House confined ο Hospital confined?

Does the patient currently need another person's help in performing any activities of daily living, such as ο bathing ο dressing ο toileting ο eating ο walking indoors ο transferring from bed to chair ο controlling bladder or bowel functions ο taking medications as prescribed ?

_____

_____

CARDIAC (if applicable)

(a) Functional capacity: ο Class 1 (no limitation) ο Class 2 (slight limitation) ο Class 3 (marked limitation) ο Class 4 (complete limitation)

(b) Blood Pressure latest visit (systolic/diastolic) _____

(c) Last METS rating: Date of test: _____

VISUAL IMPAIRMENT (if applicable)

(a) What was vision at latest observation with glasses?

(b) What was vision at latest observation without glasses?

(c) Vision can be restored in whole or in part: ο Yes ο No If "Yes", by what means?

PROGNOSIS

Please indicate date when patient will again be able to perform any of the above activities of daily living

DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHEQUES AND DIRECT THE USE OF PROCEEDS THEREOF? ο Yes ο No

REMARKS

Physician's Name _____ Certified Specialist In _____

Address_____ Telephone Number_____

Date _____ M.D. Signature _____