Manulife Financial

Claim number	LTD ◯
	STD ◯
	W of P ◯

Group Benefits
Attending Physician's Update

The purpose of this statement is to assist Manulife Financial in the ongoing management of your patient's claim for disability benefits. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife Financial 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 CLAIM.

1 Patient authorization

Name of patient (last, first, middle initial)	Plan contract number	Plan member certificate number

Address

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

I hereby authorize the release to Manulife Financial any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results, my medical history, treatment, and hospital records, for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments. **I understand that I am responsible for any fees related to the completion of this form.**
I understand that Manulife Financial's Privacy Policy and related materials on how and why Manulife Financial collects, uses, maintains and discloses my personal information, is available upon request; on Manulife Financial's Web site: www.manulife.ca, or through my Plan Sponsor.

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

2 Diagnosis

a) Primary

b) List any additional conditions or complications.

c) Subjective symptoms

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

3 Physical impairment

Does your patient have a physical impairment?

◯ Yes ◯ No

If yes, please complete this section.

Based on objective findings what is patient's physical level of ability for:

lifting	(max. weight/frequency)	sitting	(how long/frequency)
		standing	(how long/frequency)
carrying	(max. weight/distance)	walking	(distance/frequency)

Please provide copies of consultation reports, test results (include copies of current x-rays, EKGs or laboratory data and any relevant data) and list all abnormal findings supporting the above restrictions.

Remarks

4 Cognitive/Mental impairment

Does your patient have a cognitive/mental impairment?

◯ Yes ◯ No

If yes, please complete this section.

Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof?

◯ Yes ◯ No

Indicate if patient has cognitive/mental restrictions in the following areas.

	None	Mild	Moderate	Severe
◯ concentration				
◯ analytical reasoning				
◯ learning new material				
◯ comprehension				
◯ social interaction				

What is the DSM IV diagnosis? (Axis 1)	What is the current GAF?

Please provide copies of consultation reports and your most recent mental status test results and list all abnormal findings supporting the above restrictions.

Remarks

5 Cardiac (if applicable)

a) Functional capacity (American Heart Association)

◯ Class 1 (no limitation) ◯ Class 2 (slight limitation)
◯ Class 3 (marked limitation) ◯ Class 4 (complete limitation)

b) Blood pressure (last 3 visits)

SYSTOLIC ___ / ___ DIASTOLIC
SYSTOLIC ___ / ___ DIASTOLIC
SYSTOLIC ___ / ___ DIASTOLIC

6 Visual impairment (if applicable)

At last examination, what was patient's vision?

OD	with corrective lenses		without corrective lenses	
OS	with corrective lenses		without corrective lenses	

Can vision be fully or partially restored, if so what are the treatment plans? ◯ Yes ◯ No

7 Treatment update

Frequency of visits	Date of last 3 visits (dd/mmm/yyyy)	Date of next scheduled visit (dd/mmm/yyyy)
Weekly	1.	
Monthly	2.	
Other (specify)	3.	

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

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

If "Yes"	Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)
	Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)
	Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)

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

Name	Specialty	Address

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

Is there potential for future improvement? ◯ Yes ◯ No
If "No", please comment.

If "Yes", when do you expect a significant change in the functional limitation affecting your patient?

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

8 Physician's authorization

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial 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.

Attending physician (please print)

Certified specialist	Telephone (include area code) ( )
Address (number, street, city, province, postal code)	Fax (include area code) ( )
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.