BLUE CROSS®

ATTENDING PHYSICIAN'S STATEMENT GENERAL

10009-108 Street NW, Edmonton, Alberta T5J 3C5

PHONE: (780) 498-8100 or 1-800-232-1914
FAX: 780-441-2605 or 780-498-5991
Toll free FAX: 1-855-660-2605

INSTRUCTIONS:

1. Please Print.
2. Part I to be completed by patient.
3. Part II to VI to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

PART I: PATIENT AUTHORIZATION

Name: _____ (Last / First / Initial) Date of Birth: _____ (YYYY / MM / DD)

I hereby authorize the release of any information herein requested by my insurer or its agent.

Signature: _____ Date: _____ (YYYY / MM / DD)

PART II: ATTENDING PHYSICIAN'S STATEMENT

Name: _____ Specialty: _____

Address: _____

_____

_____

Telephone: (_____) _____ Fax: (_____) _____

PART III: HISTORY OF PRESENT CONDITION(S)

1. If condition is related to pregnancy, indicate date or expected date of delivery: _____ (YYYY / MM / DD)
   (Please attach prenatal clinical notes)

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

   a) Have Worker's Compensation/CSST forms been completed? ☐ Yes ☐ No ☐ Unknown

3. a) Primary Diagnosis: _____ Scale: DSM (_____) Grade (_____)

   _____ Class (_____) Stage (_____)

   b) Secondary Diagnosis: _____ Scale: DSM (_____) Grade (_____)

   _____ Class (_____) Stage (_____)

   c) Date symptoms first appeared or accident happened: _____ (YYYY / MM / DD)

   d) Initial Examination Date: _____ (YYYY / MM / DD)

   e) Date patient ceased working due to this condition: _____ (YYYY / MM / DD)

   f) Symptoms (include severity & frequency):

   _____

   g) Clinical Findings **(Please attach copies of x-rays, test results, etc)**:

   _____

   h) Functional limitations/restrictions, please specify length of time or maximum weight

   Sitting: _____ Standing: _____ Walking: _____ Lifting: _____ Carrying: _____ Bending: _____

   i) Expected duration of restrictions/limitations: _____

PART IV: FACTORS AFFECTING RECOVERY

- ☐ Addiction _____
- ☐ Diet _____
- ☐ Work Environment _____
- ☐ Home Environment _____
- ☐ Family History of Present Condition _____
- ☐ General Fitness _____
- ☐ Current Height: _____ Weight: _____ Right or left hand dominant: _____
- ☐ Past Medical History _____
- ☐ Pre-existing Conditions _____

Has the patient previously had a similar condition? ☐ Yes ☐ No If yes, please specify date of initial onset: _____

PART V: MANAGEMENT PLAN FOR THE CURRENT CONDITION

DATE YYYY MM DD

- ☐ Frequency of visits: _____ ____ | ____ | ____
- ☐ Date of most recent visit: _____ ____ | ____ | ____
- ☐ Hospitalization dates – **Please include Admission/Discharge Summaries**
  - _____ ____ | ____ | ____
  - _____ ____ | ____ | ____
  - _____ ____ | ____ | ____
- ☐ Surgery date(s) and Type– **Please include Operative Report**
  - _____ ____ | ____ | ____
  - _____ ____ | ____ | ____
  - _____ ____ | ____ | ____
- ☐ Medication **(include dosage)**
  - _____ ____ | ____ | ____
  - _____ ____ | ____ | ____
  - _____ ____ | ____ | ____
  - _____ ____ | ____ | ____

	Name	**Specialty**	YYYY MM DD
☐ Specialist			____ | ____ | ____
☐ Chiropractor			____ | ____ | ____
☐ Counsellor			____ | ____ | ____
☐ Additional Planned Testing			____ | ____ | ____
☐ Therapist			____ | ____ | ____
☐ Other			____ | ____ | ____

Is patient following the recommended treatment program? ☐ Yes ☐ No

PART VI: ESTIMATED TIME FOR RECOVERY

Patient progress:

☐ None ☐ Regressed ☐ Minimal Improvement ☐ Significant Improvement ☐ Plateaued ☐ Resolved

Prognosis: ☐ Poor ☐ Good

Expected duration of recovery period: _____

In your opinion, is patient a suitable candidate for medical or functional rehabilitation (i.e. conditioning program, counselling, etc.)?

☐ Yes ☐ No Please elaborate on your opinion:

In your opinion, is patient a suitable candidate for a work re-entry program (i.e. ease back, modified duties, gradual return to work, etc)?

☐ Yes ☐ No Please elaborate on your opinion:

Additional comments, please specify any information or details which may have a significant impact on the patient's recovery from this condition:

Signature: _____ Date: _____ I _____ I _____
YYYY MM DD