SASKATCHEWAN BLUE CROSS®

CLEAR PRINT

ATTENDING PHYSICIAN STATEMENT RHEUMATOLOGY

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Instructions

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

PART I: PATIENT AUTHORIZATION

Name _____ Date of Birth _____ I _____ I _____
Last First Initial YYYY MM DD

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

Signature _____ Date _____

PART II: ATTENDING PHYSICIAN

Name _____ Specialty _____

Address _____

Telephone _____ Fax _____ Email _____

Part III: HISTORY OF PRESENT CONDITION(S)

1. Primary diagnosis _____
2. Secondary diagnosis _____
3. Date symptoms first appeared _____ I _____ I _____ (YYYY MM DD)
4. Initial examination date _____ I _____ I _____ (YYYY MM DD)
5. Date patient ceased working due to this condition _____ I _____ I _____ (YYYY MM DD)
6. RHEUMATOID ARTHRITIS

   List joints involved _____

   Is objective evidence of synovitis and joint deformity present? ☐ Yes ☐ No

   Is contracture, ankylosis or impaired range of motion present? ☐ Yes ☐ No

   If yes, describe _____

   Laboratory findings

   ☐ Positive synovial fluid findings _____ ☐ A.N.A. _____ Normal _____

   _____ ☐ Rheumatoid factor titer _____ Normal _____

   ☐ Histologic change from biopsy _____ ☐ Sedimentation rate _____ Normal _____

   ☐ Other _____

   Are X-ray findings characteristic of, or compatible with Rheumatoid Arthritis? ☐ Yes ☐ No

   Results of medical or surgical treatment _____
7. OSTEOARTHRITIS

   List joints involved _____

   Is joint deformity and/or limitation of motion present? ☐ Yes ☐ No If yes, describe _____

   _____

   Are X-ray findings characteristic of, or compatible with degenerative joint disease? ☐ Yes ☐ No

   Results of medical or surgical treatment _____
8. OTHER RHEUMATIC DISEASE

   ☐ Reiter's Syndrome ☐ Ankylosing spondylitis

   ☐ Connective tissue disorders _____ ☐ Other _____

   Do X-ray findings confirm diagnosis? ☐ Yes ☐ No If yes, describe _____

   _____
9. FUNCTIONAL STATUS

Patient is able to	Frequency	Duration
Sit		
Stand		
Walk		
Drive a car		
Bend/twist		
Squat/kneel/crouch		
Climb stairs		
Reach above shoulder level		
Reach below shoulder level		
Lift up to 10 lb / 5 kg		
20 lb /10 kg		
50 lb /25 kg		

Dominant hand (circle one) **LEFT** **RIGHT**

Can the patient use his/her hands and fingers for gross or fine movements? Please specify.

Is the patient independent for activities of daily living, i.e., bathing, dressing, toileting, transferring, mobility, etc.?

List any assistive devices or aids that would improve the patient's ability to use his/her hands or to increase ability to sit, stand or walk

_____

What reasonable job or work site modifications could the employer make to assist the patient in returning to work?

_____

_____

Part IV: FACTORS AFFECTING RECOVERY

☐ Current height _____ weight _____

☐ General fitness _____

☐ Work environment _____

☐ Home environment _____

☐ Significant complaints out of proportion with clinical findings _____

_____

☐ Significant emotional or behavioural disorder, such as depression, addiction, etc. _____

_____

Has the patient previously had a similar condition? ☐ Yes ☐ No If yes, 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 _____ _____ | | _____

☐ Date of re-evaluation _____ _____ | | _____

☐ Hospitalization dates - include admission/discharge summaries

_____ _____ | | _____

_____ _____ | | _____

_____ _____ | | _____

_____ _____ | | _____

☐ Surgery date(s) and type(s) - include operative report(s)

_____ _____ | | _____

_____ _____ | | _____

_____ _____ | | _____

☐ Medication – include dosage

_____ _____ | | _____

_____ _____ | | _____

_____ _____ | | _____

_____ _____ | | _____

Name of other healthcare providers **Specialty**

☐ Specialists _____ _____ _____ | | _____

☐ Counsellor _____ _____ _____ | | _____

☐ Therapist _____ _____ _____ | | _____

☐ Other _____ _____ _____ | | _____

Is the patient following recommended treatment program? ☐ Yes ☐ No If no, explain circumstances _____

_____

_____

PART VI: ESTIMATED TIME FOR RECOVERY

1. Patient progress ☐ None ☐ Regressed ☐ Minimal Improvement ☐ Significant Improvement ☐ Plateaued ☐ Resolved

   Prognosis ☐ Poor ☐ Good

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

   ☐ Yes ☐ No Provide comments and recommendations, including any restrictions with respect to return to work.

   _____

   _____

   _____

3. Any additional information or details that may have a significant impact on the patient's recovery from this condition?

   _____

   _____

   _____

   _____

Signature _____ Date _____