ATTENDING PHYSICIAN'S STATEMENT
CRITICAL CONDITION BENEFIT

Part 1: Patient Authorization

Patient's Name	Date of Birth _____ DD/MM/YY
I hereby authorize the release to my insurer and my policyholder of any information in respect of this application. Patient's Signature	Date _____ DD/MM/YY

Part 2: Attending Physician's Statement

Diagnosis:

A) Primary

B) Secondary

C) Additional conditions or complications

Date symptoms appeared. _____ DD/MM/YY	Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, give dates and details:

Date patient first received medical treatment, diagnostic measures, medication, or consultation for this condition. _____ DD/MM/YY

Date of first treatment for this condition, if different from above. _____ DD/MM/YY	Date of last treatment for this condition. _____ DD/MM/YY
Was patient in hospital? ☐ Yes ☐ No	Name and address of hospital.

Date of hospital treatment.

Outpatient: _____ DD/MM/YY **OR** Inpatient Admission: _____ DD/MM/YY Discharge: _____ DD/MM/YY

Surgical treatment, if any: Details:

Date: _____ DD/MM/YY

Are you aware of other physician(s) who treated this patient due to this present condition? ☐ Yes ☐ No
If yes, please give name(s) and address(es):

Please summarize your patient's medical history (attach copies of tests administered including the results of any relevant clinical findings).

List all objective findings:	List all subjective findings:

Please indicate how activities of daily living are affected by this condition.

Eating _____

_____

Dressing _____

_____

Bathing _____

_____

Ambulation _____

_____

Toileting _____

_____

Cardiac functional capacity (if applicable)
(Canadian Cardiovascular Society)

☐ Class 1	☐ Class 2	☐ Class 3	☐ Class 4
No limitations	Slight limitations	Marked limitations	Complete limitations

Please forward results of stress tests, angiogram, etc.

Please outline your prognosis for this patient (refer to the list of critical conditions).

Remarks:

Physician's Name (Print)	Address	
Telephone No. ( )	Signature	Date