



CSSEIP

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

EMPLOYER NAME: _____

This form may be given to the patient, at the physician's discretion or mailed directly to Canada Life at: PO Box 1055, Winnipeg, MB R3C 2X4 or emailed to the appropriate Canada Life Disability Management Services Office:

- Calgary: calgary.dms@canadalife.com
- Langley: langley.dms@canadalife.com
- Vancouver: vancouver.dms@canadalife.com

Patient's Name: _____ Telephone #: _____

Height: _____ Weight: _____ Date of Birth:

| | | |
|-----|-------|------|
| | | |
| Day | Month | Year |

 HBT Benefits ID No. (BID) _____

Physician – Important Notice

The detailed completion of this form is of vital importance to your patient, as this medical evidence is essential to enable the patient's Community Social Services Early Intervention Program (CSSEIP) claim to be processed. Please complete the sections relating to your patient and strike out non-applicable areas. The back page is available to expand on comments under any of the headings or to add other information relevant to the claim. Copies of this form and other medical reports will be released to the patient when requested in writing by the patient.

Physician's Name: (Please print) _____ Telephone #: _____

Address: _____
Number & Street City Province Postal Code

Signature: _____ Date: _____

Specialty, if any: _____

Claimant's Authorization

I hereby authorize the release to Canada Life and to the Trustees of the Healthcare Benefit Trust (Trust), and their agents of any information requested in respect of the claim. I understand that I am responsible for any charges that may be made for the completion of this form.

Signature: _____ Date: _____

1. Primary Diagnosis

a) Diagnosis: _____

b) Is the patient's condition due to injury or sickness arising out of the patient's employment?

- Yes No Unknown

c) Date of onset of symptoms or of accident:

| | | |
|-----|-------|------|
| | | |
| Day | Month | Year |

d) Date of first visit by patient for this condition:

| | | |
|-----|-------|------|
| | | |
| Day | Month | Year |

e) **Supporting clinical evidence of present condition(s): Provide copies of all clinical notes, consultation reports, test results, functional testing and any other evidence supporting the present condition(s) from the date on which they became disabling to the present.** Attached: Yes None available

f) Present treatment: _____

g) Future treatment plan: _____

h) Prognosis: _____

2. Secondary Diagnosis

a) Diagnosis: _____

b) To what extent does the secondary diagnosis contribute to the patient's condition?

Significantly

Slightly

Equally with primary diagnosis

Not a contributing factor

c) Supportive evidence: _____

d) Present treatment: _____

e) Future treatment plan: _____

f) Prognosis: _____

3. Other Complicating Factors

a) Diagnosis: _____

b) Supportive evidence: _____

c) Present treatment: _____

d) Future treatment plan: _____

e) Prognosis _____

4. Specialists

a) Names, addresses and specialities of other treating and consulting physicians:

6. Functional Overlay

a) Are the clinical findings proportional to the patient's complaints? Yes No If no, explain:

b) If your answer to a) is "no", has the patient been referred for psychiatric assessment and/or treatment? If not, would a psychiatric assessment and/or treatment be useful?

7. Clinical Findings and Observations

a) Please describe how the condition(s) have impacted the following, and to what degree:

DEGREE OF IMPACT

| | None | Mild | Moderate | Severe |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Appearance _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Memory _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Energy vigour _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Behaviour _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Decision making _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Socialization _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Concentration/focus _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Speech _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Affect/mood _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insight/judgement _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-criticism _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

b) Observations or comments supporting the above: _____

8. Complicating Factors

a) Indicate all factors that have contributed to the clinical problem(s) and may complicate your patient's recovery period:

- Workplace issues Social/family issues Financial/legal problems Physical condition
 Alcohol/drug abuse Medication side effects Pain perception Coping skills
 Personality/motivation Other

Please describe: _____

b) Please describe the supports in place, or planned, to assist with these issues: _____

9. Additional Information
