beneva

Physician's initial statement

Insurance Policy No.: _____

First and last names _____

Last name at birth _____ Date of birth Y Y Y Y M M D D

Declaration of the attending physician (to be completed in block letters and given to the patient)

1. Diagnosis

1.1 Principal: _____

1.2 Secondary: _____

1.3 Complications: _____

1.4 Is the disability related to: ☐ an accident ☐ a sickness ☐ a work accident ☐ a motor vehicle accident

1.5 For the illness(es) or symptoms associated to the diagnosis, has the patient already:

☐ received treatment(s) ☐ consulted another physician ☐ taken medication(s) ☐ been hospitalized ☐ undergone medical testing

Specify the time periods: _____

1.6 In relation to the diagnosis, please identify the patient's limitations that prevent him/her from working or carrying out their usual activities:

At onset of disability

☐ Preparing meals and/or eating
☐ Managing medication
☐ Walking/moving around outside the home
☐ Interior home maintenance/housekeeping
☐ Walking/moving around inside the home
☐ Personal hygiene
☐ Exterior home maintenance
☐ Driving a motor vehicle
☐ Other, specify: _____

As of today

☐ Preparing meals and/or eating
☐ Gérer la médication
☐ Walking/moving around outside the home
☐ Entretien ménager maintenance/housekeeping
☐ Walking/moving around inside the home
☐ Personal hygiene
☐ Exterior home maintenance
☐ Driving a motor vehicle
☐ Other, specify: _____

2. Treatment

2.1 Prescribed medications – name and dosage: _____

2.2 Has the patient undergone or will the patient undergo:

- medical examinations or tests? ☐ Yes ☐ No Specify: _____

- a surgery? ☐ Yes ☐ No Is it a day surgery? ☐ Yes ☐ No

Type of surgical procedure: _____ Date : Y Y Y Y M M D D

Hospitalization period from Y Y Y Y M M D D to Y Y Y Y M M D D

Name of hospital: _____

- Will he/she receive other treatments? ☐ Yes ☐ No Specify: _____

- Was there a short term stay under observation (no. of hours): _____

Please continue on the other side.

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Y Y Y Y M M D D

Other consultation dates: _____

Date of next consultation: Y Y Y Y M M D D Frequency of follow-ups: _____

3.2 Referral to another physician? ☐ Yes ☐ No

Name of physician: _____ Specialty: _____

3.3 Approximate duration of disability: no. months _____ no. weeks _____ no. days _____ ☐ undetermined

a) Is the patient capable of autonomously performing his/her regular activities or able to return to work without restrictions?

☐ Yes ☐ No If YES, since when? Y Y Y Y M M D D If NO, when can he/she? Y Y Y Y M M D D

b) Has the patient partially resumed his/her activities or progressively returned to work?

☐ Yes ☐ No If YES, since when? Y Y Y Y M M D D If NO, when can he/she? Y Y Y Y M M D D

4. Specific questions for the policy

4.1 If your patient's disability is caused by a cancer, provide the information below

Is this the first ever diagnosis of cancer? ☐ Yes ☐ No

If YES, date of first diagnosis: Y Y Y Y M M D D Type of cancer: _____

If NO, date of previous cancer diagnosis: Y Y Y Y M M D D Type of cancer: _____

4.2 In the last five (5) years, has the patient consulted or been treated by a doctor or other practitioner or taken medication prescribed by a physician for any of the following illnesses or conditions: cardiovascular or cerebrovascular disorders, cancer or tumor, AIDS or any other disorder related to AIDS, alcoholism, respiratory disorders, drug abuse, dementia, epilepsy, diabetes, kidney disease, hepatitis A, B or C?

☐ Yes ☐ No If YES, provide the information below:

Illness	Date	When was the patient informed of his/her illness?	Hospitalization period(s)

5. Identification of the physician

_____ _____

Last and first names Telephone

Licence number: _____ ☐ General practitioner ☐ Specialist, specify: _____

X _____ Y Y Y Y M M D D

Signature Date

All costs incurred in filling out this form are at the claimant's expense.