canada life™

Cancer Form

MORNEAU SHEPELL

Attending Physician's Statement

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL**

INSTRUCTIONS

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. **Any charge for completion of this form is the patient's responsibility.**

Claims Administrator: The Canada Life Assurance Company (Canada Life)/Morneau Shepell PLAN NO.

Part 1: Patient Authorization

Name | Date of birth

Address | Telephone no. ( ) –

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life/ Morneau Shepell for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life/ Morneau Shepell and administering the group benefits plan. Medical and health information excludes genetic test results.

I acknowledge that the personal information is needed by Canada Life/ Morneau Shepell for the purposes stated above. I acknowledge that my consent enables Canada Life/ Morneau Shepell to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Plan Member/Employee Signature | Date of Consent (dd/mm/yyyy)

Part 2: Attending Physician's Statement

1 DIAGNOSIS OF PRESENT CONDITION (please provide copies of all relevant clinical notes, consultation, operative and pathology reports on file.)

Date of cancer diagnosis: _____ / _____ / _____ (D / M / Y)

Site of tumor: _____

Type of tumor: _____

Histology and staging: _____

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

If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? ☐ Yes ☐ No

2 HISTORY

Date symptoms first appeared: _____ / _____ / _____ (D / M / Y)

Has patient ever had the same the same or similar condition? ☐ Yes ☐ No

If yes, please specify diagnosis and dates of treatment. _____

_____

3 FINDINGS

Describe current symptoms: _____

First visit for these symptoms: _____ / _____ / _____ (D / M / Y)

Current Height: _____ Current Weight: _____ Weight loss/gain to date: _____

In your opinion, when did the patient's condition first prevent him/her from working? _____ / _____ / _____ (D / M / Y)

4 TREATMENT

Date of first visit: _____ / _____ / _____ (D / M / Y)

Date of latest visit: _____ / _____ / _____ (D / M / Y)

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

If other, please specify _____

Treatment: Describe all treatments to date and future treatment plan, including dates of treatment and, if applicable, the duration of the treatment:

Surgery: _____

Radiation: _____

Hormones: _____

Chemotherapy: _____

Hospitalization (if applicable for this illness or injury)

Date of in-patient admission: _____ /_____ /_____ (D / M / Y)

Date of discharge: _____ /_____ /_____ (D / M / Y)

Date of out-patient treatment: _____ /_____ /_____ (D / M / Y)

Name of hospital: _____

5 PROGNOSIS

Describe response to therapies to date: _____

Describe all comorbid conditions: _____

Describe any "post therapy" sequelae: _____

Prognosis: _____

Please provide the names of other physicians who have been/will be involved in assessing the medical problems; **and copies of any available consultation reports**.

_____

_____

6 PHYSICAL ABILITIES

☐ Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

☐ Light Duties: require frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling or arm and/or leg controls.

☐ Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying pushing and pulling may also be required.

☐ Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

In your opinion, what is the earliest date your patient will be able to return to work? _____ /_____ /_____ (D / M / Y)

If the previous job could be modified, when could rehabilitation employment commence? _____ /_____ /_____ (D / M / Y)

7 COMMENTS

We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

_____

_____

_____

Name of attending physician *(please print)*	Specialty	Telephone no. *(including area code)* ( ) –
Address *(number, street, city, province, postal code)*		
Signature		Date *(day, month, year)*

Address:
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