THE Great-West Life ASSURANCE COMPANY

Attending Physician's Statement: Musculo-Skeletal Condition

Short Term Disability Income Benefits

☐ Initial Claim
☐ Supplementary Form

EMPLOYEE'S IDENTIFICATION

First Name: ____________ Last Name: ____________ PIN ____________

Address: ____________ City: ____________

Province: ____________ Postal Code: ____________

Telephone (home): ____________ Telephone (work): ____________ Date of Birth (YY/MM/DD): ____________

Social Insurance Number: ____________

I hereby authorize the release of any information requested on this form to The Great-West Life Assurance Company or any of its agents.

Signature of Patient: ____________ Date: ____________

I hereby authorize Great-West, and any successor agency, to release this form to CN Occupational Health Services (or its delegate).

Employee's Signature: ____________ Date of Consent: ____________

TO BE COMPLETED BY THE ATTENDING PHYSICIAN – MUSCULO-SKELETAL CONDITION

A. HISTORY

1. Diagnosis ____________
2. Precipitating event ____________
3. Date symptoms first appeared Year ______ Month ______ Day ______
4. In your opinion, when did the patient's condition first prevent him/her from working? Year ______ Month ______ Day ______
5. Has patient ever had same or similar condition? ☐ No ☐ Unknown ☐ Yes Please state and describe ____________

6.. Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Unknown ☐ Yes
7. Date of first visit Year ______ Month ______ Day ______
8. Date of latest visit Year ______ Month ______ Day ______
9. Frequency of visit ☐ Daily ☐ Weekly ☐ Monthly ☐ Other (please specify) ____________
10. Please outline all objective studies performed (X-rays, laboratory data, C.T. scans, etc.) and attach copies of each report.

Date	Procedure	Results

11. Please indicate the nature and severity of the patient's symptoms and signs.

	Location(s)	Severe	Moderate	Mild	Absent
Pain		☐	☐	☐	☐
Deformity		☐	☐	☐	☐
Muscle Spasm		☐	☐	☐	☐
Muscle Atrophy		☐	☐	☐	☐
Loss of Tendon Reflexes		☐	☐	☐	☐
Sensory Change		☐	☐	☐	☐
Motor Deficit		☐	☐	☐	☐
Straight Leg Raising Limitation		☐	☐	☐	☐
Range of Motion Limitation		☐	☐	☐	☐
Other (specify)		☐	☐	☐	☐

12. If Arthritic Condition ☐ In Remission ☐ Continuously Active ☐ Stable
☐ Seasonally Active ☐ Intermittently Active ☐ Progressive
13. If Fracture ☐ Closed ☐ Depressed ☐ Open ☐ Compressed ☐ Comminuted
14. If Reduction Required ☐ Open ☐ Closed

B. TREATMENT

1. Please provide treatment details:	Name	Dosage	Commenced	Expected Duration
Analgesics				
Steroids or N.S.A.I.D.				
Other Drug Therapy				

	Commenced	Frequency	Expected Duration
Physiotherapy			
Bed Rest (with or without traction)			
Braces/Support (specify type)			
Pain Clinic			
Weight Reduction			

2. Present Height ____________ Weight ____________ Weight Loss to Date ____________
3. Has surgery been performed? ☐ No ☐ Yes Specify date and procedure ____________
4. Are further tests or surgery anticipated? ☐ No ☐ Yes Specify date, procedure and hospital ____________
5. Names of all other physicians and their specialties ____________
6. Complications which might affect duration of absence from work ____________

C. LIMITATIONS AND RESTRICTIONS

1. In an ____________ hour workday, this patient can:

		Hours at one time					Total hours during day				
		<1	1-2	2-4	4-6	6-8	<1	1-2	2-4	4-6	6-8
Stand	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk on uneven surfaces ☐ Yes ☐ No											
Sit	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drive	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. This patient can lift/carry a maximum of:

		kgs	0	5	9	14	18	23	27	32	36	41+
		lbs	0	10	20	30	40	50	60	70	80	90+
☐ No restriction	☐ Repetitively - How much?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally - How much?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

3. Please indicate in the space provided if this patient is able to perform the following actions **(Frequently (F), Occasionally (O) or Not at all (N):)**
   Bend ______ Squat ______ Kneel ______ Climb ______ Reach (above shoulders) ______ Reach (below shoulders) ______

D. PROGNOSIS

1. In your opinion, what is the earliest date your patient will be able to return to work? Year______ Month______ Day______
   If the previous job could be modified, when could rehabilitation employment commence? Year______ Month______ Day______

E. REMARKS

1. Is patient competent to endorse cheques? ☐ Yes ☐ No
2. Please provide comments and further details which you feel would be helpful.

____

THE PATIENT IS RESPONSIBLE FOR ANY CHARGES MADE FOR THE COMPLETION OF THIS FORM.

____
Physician's Name (please print) Specialty

____
Address (Number, street, city, province, postal code)

____
Signature Telephone Date