SASKATCHEWAN BLUE CROSS®

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ATTENDING PHYSICIAN STATEMENT
GENERAL

Instructions

1. Please print.
2. Part I to be completed by patient.
3. Part II–VI to be completed by physician.
4. Any fee for completing this form is the patient's responsibility.

PART I: PATIENT AUTHORIZATION

Name _____ Date of Birth _____ I _____ I _____
Last First Initial YYYY MM DD

I hereby authorize the release of any information herein requested by my insurer or its agent.

Signature _____ Date _____

PART II: ATTENDING PHYSICIAN

Name _____ Specialty _____

Address _____

Telephone _____ Fax _____ Email _____

Part III: HISTORY OF PRESENT CONDITION(S)

1. If condition is related to pregnancy, indicate date or expected date of delivery (attach prenatal clinical notes) ____ I ____ I ____
YYYY MM DD

2. Is condition due to injury or sickness arising from the patient's employment? ☐ Yes ☐ No ☐ Unknown
Have workers compensation forms been completed? ☐ Yes ☐ No ☐ Unknown

3. a. Primary diagnosis _____ Scale: DSM (_____) Grade (_____)
_____ Class (_____) Grade (_____)

b. Secondary diagnosis _____ Scale: DSM (_____) Grade (_____)
_____ Class (_____) Grade (_____)

c. Date symptoms first appeared or accident happened _____ I _____ I _____
YYYY MM DD

d. Initial examination date _____ I _____ I _____
YYYY MM DD

e. Date patient ceased working due to this condition _____ I _____ I _____
YYYY MM DD

f. Symptoms (include severity & frequency)

_____

_____

g. Clinical findings (attach copies of X-rays, test results, etc.)

_____

_____

h. Functional limitations/restriction (specify length of time or maximum weight)

Sitting _____ Standing _____ Walking _____ Lifting _____ Carrying _____ Bending _____

i. Expected duration of restrictions/limitations _____

j. Current height _____ weight _____

Part IV: FACTORS AFFECTING RECOVERY

☐ General fitness _____

☐ Addiction _____

☐ Diet _____

☐ Work environment _____

☐ Home environment _____

☐ Past medical history _____

☐ Pre-existing conditions _____

☐ Family history of present condition _____

Has the patient previously had a similar condition? ☐ Yes ☐ No If yes, specify date of initial onset _____

PART V: MANAGEMENT PLAN FOR THE CURRENT CONDITION

DATE (YYYY | MM | DD)

- ☐ Frequency of visits _____ _____ | _____ | _____
- ☐ Date of most recent visit _____ _____ | _____ | _____
- ☐ Date of re-evaluation _____ _____ | _____ | _____
- ☐ Hospitalization dates - include admission/discharge summaries

_____ _____ | _____ | _____

_____ _____ | _____ | _____

_____ _____ | _____ | _____

_____ _____ | _____ | _____

- ☐ Surgery date(s) and type(s) - include operative report(s)

_____ _____ | _____ | _____

_____ _____ | _____ | _____

_____ _____ | _____ | _____

- ☐ Medication - include dosage

_____ _____ | _____ | _____

_____ _____ | _____ | _____

_____ _____ | _____ | _____

_____ _____ | _____ | _____

Name of Other Health Care Providers	Specialty	
☐ Specialists _____	_____	_____ | _____ | _____
☐ Chiropractor _____	_____	_____ | _____ | _____
☐ Counsellor _____	_____	_____ | _____ | _____
☐ Therapist _____	_____	_____ | _____ | _____
☐ Additional testing planned _____	_____	_____ | _____ | _____
☐ Other _____	_____	_____ | _____ | _____

Is the patient following recommended treatment program? ☐ Yes ☐ No

PART VI: ESTIMATED TIME FOR RECOVERY

1. Patient Progress

   ☐ None ☐ Regressed ☐ Minimal Improvement ☐ Significant Improvement ☐ Plateaued ☐ Resolved

2. Patient Prognosis ☐ Poor ☐ Good

3. Expected duration of recovery period _____

4. In your opinion, is the patient a suitable candidate for medical or functional rehabilitation (i.e., conditioning program, counselling, etc.)? ☐ Yes ☐ No Explain why. _____

   _____

   _____

5. In your opinion, is the patient a suitable candidate for a work re-entry program (i.e., ease back, modified duties, gradual return to work, etc.)? ☐ Yes ☐ No Explain why. _____

   _____

   _____

6. Any additional information or details that may have a significant impact on the patient's recovery from this condition?

   _____

   _____

   _____

   _____

Signature _____ Date _____