Please return this completed form and supporting documents to:
Group Benefit Services
400-200 Main Street, Winnipeg, MB R3C 1A8
For inquiries, please call 1-800-665-7076

LONG TERM DISABILITY
PHYSICIAN STATEMENT

PATIENT AUTHORIZATION

To be completed by patient

Patient_______________________________ Group Plan #_______________
Last Name First Name

I hereby authorize the release of medical and health information in my file to Wawanesa Life and/or its authorized agents for the purpose of assessing my disability claim and administering the benefit plan. This medical and health information includes, but is not limited to, copies of all consultation reports, the clinical notes, test results and hospital records. I understand that I am responsible for any fees related to the completion of this form.

I acknowledge that the personal information is required by Wawanesa Life for the purpose stated above. I acknowledge that my consent enables Wawanesa Life to process my claim and refusing to consent may result in delay or denial of my claim.

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

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

_______________________ _______________
Patient Signature Date (dd/mm/yyyy)

CLINICAL INFORMATION

To be completed by physician

Primary Diagnosis

Secondary Diagnoses or complications

Patient's height__________Patient's weight__________ Dominant hand ☐ Right ☐ Left

Date of accident/symptoms onset Date condition first prevented patient from working

__________ (yy/mm/dd) __________ (yy/mm/dd)

Is this condition due to:

☐ Motor vehicle accident ☐ Work ☐ Other (Please specify)______________________

Current symptoms (include frequency and severity)

How have the symptoms changed to date?

Clinical findings

Has the patient had this condition before? ☐ Yes ☐ No
If 'Yes', when?

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CLINICAL INFORMATION

continued

Is your patient's condition related to issues at the workplace? ☐ Yes ☐ No

Have there been any changes in your patient's Activities of Daily Living? ☐ Yes ☐ No

Is your patient: ☐ Ambulatory ☐ Bed confined ☐ Hospital confined
☐ Ambulatory with assistive devices ☐ Home confined

Currently, what is your patient's physical ability relative to the below activities:

	Hours at one time					Total hours during day					
	<1	1-2	2-4	4-6	>6	<1	1-2	2-4	4-6	>6	
Sitting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ No restriction
Standing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ No restriction
Walking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ No restriction
Driving	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ No restriction

Lifting / Carrying	0-10 lbs	11-20 lbs	21-50 lbs	Infrequent	Frequent	Constant
Lifting-floor to waist	☐	☐	☐	☐	☐	☐
Lifting-waist to shoulder	☐	☐	☐	☐	☐	☐
Lifting-above shoulder	☐	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐	☐

PSYCHIATRIC

If disability relates to or includes psychologic symptoms

Aligning with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or similar:

Provide diagnosis and ICD-9 or ICD10 code

Current symptoms and their severity

Is the patient's condition related to drug or alcohol abuse? ☐ Yes ☐ No

Is/has the patient currently or previously enrolled in a substance abuse program? ☐ Yes ☐ No

If 'Yes', state when and what type of program?

Provide copy of relevant testing such as:
Patient Health Questionnaire - 9 (PHQ-9)
World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0).
If no such testing, why not?

VISION

If disability relates to vision

Provide visual acuity and date of last examination.

With corrective lenses		Without corrective lenses		Date of last exam
______	______	______	______	______
OD	OS	OD	OS	(yy/mm/dd)

PREGNANCY

If disability relates to pregnancy

If patient is pregnant, give Expected Date of Confinement__________ (yy/mm/dd)

Please provide copies of pre-natal records

TREATMENT INFORMATION

Date of first visit__________ (yy/mm/dd) Date of last visit__________ (yy/mm/dd)

Frequency of visits ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other (specify)______________

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TREATMENT INFORMATION

Continued

Other treating/consulting physicians or health care practitioners:

Name of practitioner	Type of practitioner	Date seen (yy/mm/dd)

Current medications:

Name	Dosage	Duration	Start Date (yy/mm/dd)	Response

Other forms of treatment or therapies:

Type	Duration	Start Date (yy/mm/dd)	Response

Hospitalizations:

Admission dates (yy/mm/dd)	Discharge dates (yy/mm/dd)	Facility	Reason (date of surgery if applicable)

Treatment response: ☐ Recovered ☐ Improved ☐ No change ☐ Retrogressed

Comments:

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

If 'No', please explain:

Please provide details of any proposed changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy etc.

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RETURN TO WORK	In your opinion, what is the earliest date your patient will be able to return to work?_______________ (yy/mm/dd) Is the patient able to participate in a rehabilitation program? ☐ Yes ☐ No Please explain:
COMPETENCY	Is the patient capable of handling his/her own financial affairs? ☐ Yes ☐ No If 'No', from what date?_______________ (yy/mm/dd)
LICENSE RESTRICTION	Has your patient's driver's license or any other professional license or certification been restricted, revoked or suspended as a result of the current condition? ☐ Yes ☐ No ☐ Restricted ☐ Revoked ☐ Suspended Date_______________ (yy/mm/dd) Type of license____________________ Class of license_______________ If 'Yes', when will your patient be eligible to apply for reinstatement of the license or certification? Date_______________ (yy/mm/dd)
REMARKS	Please provide any additional information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment; etc.

Please attach a copy of your patient's chart notes, including consultation reports and test results related to your patient's diagnosis.

PHYSICIAN INFORMATION	Name of Physician____________________ Specialty____________________ Telephone____________________ Fax____________________ Address____________________ Street & Number ________ City ________ Province ________ Postal Code The information in this statement will be kept in a group, life health or disability benefits file with Wawanesa Life and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein. ____________________ Physician Signature ____________________ Date signed (yy/mm/dd)

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