

5. Progress

Has patient: Recovered Improved Not improved Retrogressed

6. Prognosis

(a) Do you think the patient will be able to return to former occupation? YES (provide approx. date) NO (provide reasons)

(b) Do you think patient will be able to perform any occupation? YES (provide approx. date) NO (provide reasons)

7. Rehabilitation

(a) Is patient a suitable candidate for some form of medical or vocational rehabilitation? YES (specify) NO (provide reasons)

8. Tobacco Usage

Please provide details of your patient's tobacco use including amount per day and date last used.

9. Remarks

Please provide any further details which you feel would be helpful.

ATTENDING PHYSICIAN INFORMATION AND SIGNATURE

NAME SPECIALTY TEL.

ADDRESS

DATE _____ SIGNATURE _____

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION

**PLEASE SEND REPORT TO:
The Wawanesa Life Insurance Company,
400 – 200 Main Street, Winnipeg, Manitoba R3C 1A8
FAX: 1-888-985-3872**