Healthcare Benefit Trust (HBT) Policy 51337 ☐
Joint Community Benefits Trust (JCBT) Policy 59234 ☐
Joint Facilities Benefits Trust (JFBT) Policy 59233 ☐
Joint Health Science Benefits Trust (JHSBT) Policy 59232 ☐
Community Social Services Employers' Association (CSSEA) HBT Policy 51367 ☐
Healthcare Benefit Trust (HBT) Policy 50168 ☐

Claim for Long Term Disability Benefits

EMPLOYER NAME: _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

This form may be given to the patient, at the physician's discretion or mailed directly to Canada Life at:

☐ Vancouver: #1500 – 1055 Dunsmuir Street, Vancouver, BC V7X 1K8
☐ Langley: 2nd floor, 8700 – 200 Street, Langley, BC V2Y 0G4

Patient's Name: _____ **Telephone #:** _____

Height: _____ **Weight:** _____ **Date of Birth:** ____ ____ ____ (Day Month Year) **HBT Benefits ID No. (BID)** _____

Physician – Important Notice

The detailed completion of this form is of vital importance to your patient, as this medical evidence is essential to enable the patient's disability claim to be processed. Please complete the sections relating to your patient and strike out non-applicable areas. The back page is available to expand on comments under any of the headings or to add other information relevant to the claim. Copies of this form and other medical reports will be released to the patient when requested in writing by the patient.

Physician's Name: (Please print) _____ **Telephone #:** _____

Address: _____
Number & Street City Province Postal Code

Signature: _____ **Date:** _____

Specialty, if any: _____

Claimant's Authorization

I hereby authorize the release to Canada Life and to the Trustees of the Trust, as indicated on page one of my Claimant's Statement, and their agents of any information requested in respect of the claim. I understand that I am responsible for any charges that may be made for the completion of this form.

Signature: _____ **Date:** _____

1. Primary Diagnosis

a) Diagnosis: _____

b) Is the patient's condition due to injury or sickness arising out of the patient's employment?

☐ Yes ☐ No ☐ Unknown

c) Date of onset of symptoms or of accident: ____ ____ ____ (Day Month Year)

d) Date of first visit by patient for this condition: ____ ____ ____ (Day Month Year)

e) <u>Supporting clinical evidence of present condition(s):</u> ***<u>Provide copies of all clinical notes, consultation reports, test results, functional testing and any other evidence supporting the present condition(s) from the date on which they became disabling to the present</u>***.

Attached: ☐ Yes ☐ None available

f) Present treatment:

g) Future treatment plan:

h) Prognosis:

2. Secondary Diagnosis

a) Diagnosis:

b) To what extent does the secondary diagnosis contribute to the patient's condition?

- ☐ Significantly
- ☐ Slightly
- ☐ Equally with primary diagnosis
- ☐ Not a contributing factor

c) Supportive evidence:

d) Present treatment:

e) Future treatment plan:

f) Prognosis:

3. Other Complicating Factors

a) Diagnosis:

b) Supportive evidence:

c) Present treatment:

d) Future treatment plan:

e) Prognosis

4. Specialists

a) Names, addresses and specialities of other treating and consulting physicians:

b) If patient has not seen a specialist, please indicate reason:

5. Current Functional Limitations

a)

FUNCTION	None	Slight	Moderate	Severe	Don't know
Judgement	☐	☐	☐	☐	☐
Decision-making	☐	☐	☐	☐	☐
Attention	☐	☐	☐	☐	☐
Concentration	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Sensation	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐
Please indicate maximum recommended weight _____ ☐ lbs ☐ kgs					
Dexterity	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Any other functions limited by the illness or injury:					
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

b) Describe any functional limitations, physical or psychological, which you consider to be major obstacles to the patient's ability to work.

c) Were any functional capacity evaluations performed? ☐ Yes ☐ No

If yes, state type, provide date performed and enclose copy, if available: Day ____ Month ____ Year ____

d) What return-to-work goals have been discussed with your patient? Please explain:

e) What date has been discussed for your patient's return to work? Day ____ Month ____ Year ____

f) Regular duties: Can your patient return to full regular duties? ☐ Yes ☐ No

If no, please describe what job modifications would be needed in order to return to work:

g) Please provide any other information that will help us to understand the patient's current condition, recovery goals and prognosis:

h) Would your patient benefit from medical or vocational rehabilitation services (i.e. conditioning program, psychological counselling, addition program, vocational counselling, etc.)? ☐ Yes ☐ No

6. Functional Overlay

a) Are the clinical findings proportional to the patient's complaints? ☐ Yes ☐ No If no, explain:

b) If your answer to a) is "no", has the patient been referred for psychiatric assessment and/or treatment? If not, would a psychiatric assessment and/or treatment be useful?

7. Clinical Findings and Observations

a) Please describe how the condition(s) have impacted the following, and to what degree:

	DEGREE OF IMPACT			
	None	Mild	Moderate	Severe
Appearance	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration/focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect/mood	☐	☐	☐	☐
Insight/judgement	☐	☐	☐	☐
Self-criticism	☐	☐	☐	☐

b) Observations or comments supporting the above:

8. Complicating Factors

a) Indicate all factors that have contributed to the clinical problem(s) and may complicate your patient's recovery period:

☐ Workplace issues ☐ Social/family issues ☐ Financial/legal problems ☐ Physical condition
☐ Alcohol/drug abuse ☐ Medication side effects ☐ Pain perception ☐ Coping skills
☐ Personality/motivation ☐ Other

Please describe:

b) Please describe the supports in place, or planned, to assist with these issues:

9. Additional Information

Clear Data