

Attending Physician Statement Section

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Policy Number _____

1. Patient's Name _____ 2. Patient's Age _____

3. Diagnosis of present condition _____

(a) Primary _____

(b) Secondary (if applicable) _____

4. On what dates did you examine the patient? D M Y D M Y D M Y

5. To the best of my knowledge

(a) Symptoms first appeared or accident happened D M Y

(b) Patient has had same or similar condition? Yes No

If "Yes", state particulars _____

6. If attended at hospital, name of hospital _____

Admitted D M Y Time _____ AM/PM

Discharged D M Y Time _____ AM/PM

7. If surgery performed, describe _____

8. If patient referred to you, give name of referring physician _____

9. Have you referred the patient to a specialist for additional treatments? Yes No

If "Yes", please explain _____

10. Have you referred the patient for physiotherapy treatments? Yes No If yes, date such referral was made: D M Y

Frequency and duration of physiotherapy treatments? _____

Physician's Name (Print) _____ Physician's Signature _____

Address _____

Street

City

Province

Postal Code

Telephone () _____

Date D M Y

The patient is responsible for securing this form and for any charges made for its completion.