Initial Attending Physician's Statement

Instructions to the Insured:

- Please complete, sign and date Section 1.
- Ask your physician to complete Section 2.

Please note that you, the Insured, are responsible for the cost of completing this form.

Instructions to the Physician:

- Please complete, sign and date Section 2.
- Please enclose copies of chart notes, consultation reports, investigations and test results that relate to your patient's claim for disability*.

*ivari will disburse up to a $75.00 administration fee for photocopying upon receipt of your patient's records. If this amount is unreasonable due to the size of your patient's chart, please call 1-855-806-5057 and ask the claims department to request an alternative fee.

CL1008 9/15

Initial Attending Physician's Statement

General Information

1 Insured Information

THIS PART OF THE FORM SHOULD BE COMPLETED BEFORE THE PHYSICIAN COMPLETES SECTION 2

Privacy Notice: I understand that the information collected on this claim form, and otherwise in connection with my claim, is required by *ivari*, its reinsurers and authorized administrators (the "Insurer") for insurance purposes. Examples of insurance purposes include: determining whether there is insurance coverage, investigating and administering claims, evaluating my ability to work, co-ordinating benefits with other insurers and fraud detection. For insurance purposes, the Insurer will consult its existing files, may collect additional information from and about me, including background checks, and, where required, exchange information about me with third parties. This collection, use and disclosure of personal information enables *ivari* to administer claim(s).

Your personal information may be used, stored or accessed in other countries and may be subject to the laws of those countries. Information may be disclosed in response to demands or requests from government authorities, courts, or law enforcement in these countries.

For more details about *ivari's* Privacy Policy, please visit us at: **www.ivari.ca**.

A person may refuse to consent to this collection, use and disclosure of personal information. However, in that event *ivari* may be unable to provide claims services and this may result in delays in processing, or denial, of claim(s).

ivari requires a Social Insurance Number for tax related purposes only and shall share it with the appropriate government agencies where required by law.

INSURED INFORMATION

PLEASE PRINT CLEARLY

Name _____

Policy Number(s) _____ Date of Birth D D / M M / Y Y Y Y Height (cm) _____ Weight (kg) _____

Occupation _____ Employer (if applicable) _____

PATIENT'S AUTHORIZATION

I hereby authorize any person with relevant information about me, including but not limited to any physician or other health care provider, hospital or other health care institution or medically related facility, any insurance company or reinsurance company, accountant(s), employer, workers compensation board or similar plan and any governmental department, to release and exchange with *ivari*, or a representative thereof, all personal information (including personal health information, benefit payment or financial information), about me in its possession that is requested by *ivari* for insurance purposes.

This authorization does not have any expiry date and it will remain valid for as long as I am claiming eligibility for benefits or services from *ivari*. I, the undersigned, agree that a photocopy or electronic copy of this authorization as executed by me will be as valid as the original.

Insured's signature _____ **PRINT TO SIGN** _____ Date D D / M M / Y Y Y Y

2 Physician's Report

To assist us in adjudicating your patient's claim, we kindly ask that you complete this statement as thoroughly as possible.

ivari will use the information in this form to determine your patient's eligibility for disability benefits.

Please be assured that the information, including the medical records requested will be treated confidentially.

Any information provided by you to *ivari* regarding this claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of your patient or harm to a third party.

We thank you in advance for your cooperation and please note that the patient is responsible for any charges incurred in the completion of this form.

Documents Required* (as applicable)

Copies of all:
- investigation reports
- laboratory data
- consultation reports
- clinical notes
- hospital admission, histories and discharge summaries

*ivari will disburse up to a $75.00 administration fee for photocopying upon receipt of your patient's records. If this amount is unreasonable due to the size of your patient's chart, please call 1-855-806-5057 and ask for the claims department to request an alternative fee.

DIAGNOSIS

Primary _____

_____

_____

Secondary _____

_____

_____

Date of disability: D D / M M / Y Y Y Y

Symptoms – Please describe the symptoms, including severity, frequency, and duration.

_____

_____

_____

Physical Findings – Please describe the clinical findings in relation to the claimed disability.

_____

_____

_____

MEDICAL HISTORY

1. What was the date of the patient's first appointment for the claimed disability? Date D D / M M / Y Y Y Y
2. What was the date of the patient's latest appointment? Date D D / M M / Y Y Y Y
3. How often are the patient's appointments?
   ○ Weekly ○ Bi-weekly ○ Monthly ○ Other (Please specify): _____
4. Did you recommend that the patient stop work?
   ○ Yes ○ No If ***"Yes"***, as of what date? Date D D / M M / Y Y Y Y
5. Was the patient's disability caused by an accident?
   ○ Yes ○ No If ***"Yes"***, give details and the date of the accident. Date D D / M M / Y Y Y Y

   _____

   _____
6. When did the symptoms first appear? Date D D / M M / Y Y Y Y
7. Has the patient ever had a similar or related condition?
   ○ Yes ○ No If ***"Yes"***, state when and describe the condition. _____

   _____
8. Is the condition due to injury or illness caused by employment?
   ○ Yes ○ No If ***"Yes"***, give details. _____

   _____
9. Has the patient had any licences or certifications restricted or revoked (e.g. driver's licence, professional certification)?
   ○ Yes ○ No If ***"Yes"***, give details. _____

   _____
10. Is the condition due to or related to pregnancy?
    ○ Yes ○ No If ***"Yes"***, give date of confinement. Date D D / M M / Y Y Y Y

11. Investigations

    Describe the results of any examinations, laboratory tests, X-rays, ECGs, and all other investigations related to the patient's disability. Please include copies of test results and reports.

12. Precipitating chronological events:

13. Are work related issues contributing to your patient's condition?

14. Familial risk factors:

15. Complicating factors:

    Please describe all factors that may have contributed to the onset of the clinical problem(s) or may complicate their resolution:

    ☐ Workplace issues ☐ Alcohol/Drug abuse ☐ Financial/Legal Problems
    ☐ Coping skills ☐ Physical/Mental condition ☐ Other issues
    ☐ Social/Family issues ☐ Personality/Motivation

    Please comment below:

PHYSICAL IMPAIRMENT IF APPLICABLE

☐ Class 1 – No limitation of functional capacity; capable of heavy work; no restrictions. (0-10%)
☐ Class 2 – Medium manual activity. (15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work. (35-55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)
☐ Specific limitation(s)? (bending, lifting, etc.) _____

CARDIAC IF APPLICABLE

1. What is the functional capacity (American Heart Association)? If Class 3 or 4, please include a copy of any stress tests or echocardiograms.

   ○ Class 1 (no limitation) ○ Class 3 (marked limitation)
   ○ Class 2 (slight limitation) ○ Class 4 (complete limitation)

2. What is the latest blood pressure reading for the patient? _____ Date D D / M M / Y Y Y Y

MENTAL/NERVOUS IMPAIRMENT IF APPLICABLE

1. What symptoms is this patient displaying that indicate a mental impairment exists?

2. Has there been a psychiatric referral? ○ Yes ○ No If ***"Yes,"*** Name of Psychiatrist _____
3. What is the diagnos(es) using the DSM V?

   Axis I _____

   Axis II _____

   Axis III _____

   Axis IV _____

   Axis V _____

   Remarks _____

PROGRESS

1. Which of the following best describes the progress of the patient's condition since the patient stopped working?

   ○ Recovered ○ Improved ○ Unchanged ○ Retrogressed
2. What is the patient's current status?

   ○ Ambulatory ○ House confined ○ Bed confined ○ Hospital confined
3. Has the patient achieved maximum medical recovery? ○ Yes ○ No If ***"No,"*** how soon do you expect further improvement?

4. What is your prognosis, please specify any expected improvement or deterioration and time frames.

5. How is your patient limited from performing his/her work? What prevents a return to full or partial duties?

6. What are the patient's restrictions (what the patient SHOULD NOT do) and why?

7. Can the patient return to part-time or modified work? ○ Yes ○ No If ***"Yes,"*** please give details.

8. What is your patient's expected return to work date?

   Full-time: Date D D / M M / Y Y Y Y Part-time: Date D D / M M / Y Y Y Y

9. Please describe any factors not mentioned above that may affect your patient's ability to return to work (such as family issues, stress in the workplace or abuse of medication, alcohol or any other substances).

TREATMENT

1. Was the patient hospitalized?

   ○ Yes ○ No If ***"Yes,"*** name of hospital/facility _____

   From D D / M M / Y Y Y Y To D D / M M / Y Y Y Y

2. Was surgery performed?

   ○ Yes ○ No If ***"Yes,"*** please complete:

DATE	TYPE OF SURGERY
D D / M M / Y Y Y Y	
D D / M M / Y Y Y Y	

3. If medication is being administered, please describe below:

MEDICATION	DOSAGE AND FREQUENCY	DATE STARTED	DATE STOPPED	RESPONSE
a)		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	
b)		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	
c)		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	
d)		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	

4. Was psychotherapy given? ○ Yes ○ No If ***"Yes,"*** give frequency, duration and response.

5. Was physiotherapy/chiropractic treatment given? ○ Yes ○ No If ***"Yes,"*** give frequency, duration and response.

6. Has the patient been referred to a rehabilitation program? ○ Yes ○ No If ***"Yes,"*** indicate:

NAME OF PROGRAM	DATE ATTENDED	DURATION
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	

7. What other treatments were given? What was the response? Please list any side effects.

8. What further treatment is being considered?

9. Have you been actively supervising this patient's care? ○ Yes ○ No If ***"No"***, explain:

10. Please give the names, specialties and appointment dates of all other treating Health Care Providers.

NAME OF HEALTH CARE PROVIDER	SPECIALTY	APPOINTMENT DATES
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y

COOPERATION AND MOTIVATION

1. Please comment on how cooperative and compliant the patient has been with the treatment plan.

2. Additional Information

   In your opinion, is the patient capable of handling his/her own financial affairs? ○ Yes ○ No

PHYSICIAN'S REPORT

1. Remarks

   Is there any other information you wish to add that will give us a better understanding of your patient's condition?

2. Attending Physician Information

Name		
Address		
City	Province	Postal Code
Telephone Number	Fax Number	
Specialty (please give details).		

3. Attending Physician's Declaration and Signature

I certify that the statements on this form are true, complete and to the best of my knowledge.

Signature	Date
PRINT TO SIGN	D D / M M / Y Y Y Y

Please fax or mail this form to: ivari

ATTN. Disability Claims Department
5000 Yonge Street
Toronto, ON M2N 7J8
Fax: (416) 883-5715