SASKATCHEWAN
BLUE CROSS®

PO Box 4030 Saskatoon SK S7K 3T2
306.244.1192 Toll-free in Saskatchewan 1.800.667.6853
Fax 306.652.5751 www.sk.bluecross.ca

ATTENDING PHYSICIAN STATEMENT GENERAL

Instructions

1. Please print.
2. Part I to be completed by patient.
3. Part II–VI to be completed by physician.
4. Any fee for completing this form is the patient's responsibility.

PART I: PATIENT AUTHORIZATION

Name ______________________________ Date of Birth ____ | ____ | ____
Last First Initial YYYY MM DD

I hereby authorize the release of any information herein requested by my insurer or its agent.

Signature ______________________________ Date ______________

PART II: ATTENDING PHYSICIAN

Name ______________________________ Specialty ______________

Address ______________________________

Telephone ______________ Fax ______________ Email ______________

Part III: HISTORY OF PRESENT CONDITION(S)

1. If condition is related to pregnancy, indicate date or expected date of delivery (attach prenatal clinical notes) ____ | ____ | ____ YYYY MM DD
2. Is condition due to injury or sickness arising from the patient's employment? ☐ Yes ☐ No ☐ Unknown
   Have workers compensation forms been completed? ☐ Yes ☐ No ☐ Unknown
3. a. Primary diagnosis ______________________________ Scale: DSM (_____) Grade (_____) Class (_____) Grade (_____)
   b. Secondary diagnosis ______________________________ Scale: DSM (_____) Grade (_____) Class (_____) Grade (_____)
   c. Date symptoms first appeared or accident happened ____ | ____ | ____ YYYY MM DD
   d. Initial examination date ____ | ____ | ____ YYYY MM DD
   e. Date patient ceased working due to this condition ____ | ____ | ____ YYYY MM DD
   f. Symptoms (include severity & frequency)
   ____
   ____
   g. Clinical findings (attach copies of X-rays, test results, etc.)
   ____
   ____
   h. Functional limitations/restriction (specify length of time or maximum weight)
   Sitting __________ Standing __________ Walking __________ Lifting __________ Carrying __________ Bending __________
   i. Expected duration of restrictions/limitations ______________________________
   j. Current height ______________ weight ______________

Part IV: FACTORS AFFECTING RECOVERY

☐ General fitness ______________________________
☐ Addiction ______________________________
☐ Diet ______________________________
☐ Work environment ______________________________
☐ Home environment ______________________________
☐ Past medical history ______________________________
☐ Pre-existing conditions ______________________________
☐ Family history of present condition ______________________________

Has the patient previously had a similar condition? ☐ Yes ☐ No If yes, specify date of initial onset ______________

PART V: MANAGEMENT PLAN FOR THE CURRENT CONDITION

DATE (YYYY | MM | DD)

- ☐ Frequency of visits ______ | |
- ☐ Date of most recent visit ______ | |
- ☐ Date of re-evaluation ______ | |
- ☐ Hospitalization dates - include admission/discharge summaries

______ | |
______ | |
______ | |
______ | |

- ☐ Surgery date(s) and type(s) - include operative report(s)

______ | |
______ | |
______ | |

- ☐ Medication - include dosage

______ | |
______ | |
______ | |
______ | |

Name of Other Health Care Providers **Specialty**

- ☐ Specialists ______ ______ | |
- ☐ Chiropractor ______ ______ | |
- ☐ Counsellor ______ ______ | |
- ☐ Therapist ______ ______ | |
- ☐ Additional testing planned ______ ______ | |
- ☐ Other ______ ______ | |

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

PART VI: ESTIMATED TIME FOR RECOVERY

1. Patient Progress

   ☐ None ☐ Regressed ☐ Minimal Improvement ☐ Significant Improvement ☐ Plateaued ☐ Resolved

2. Patient Prognosis ☐ Poor ☐ Good
3. Expected duration of recovery period ______
4. In your opinion, is the patient a suitable candidate for medical or functional rehabilitation (i.e., conditioning program, counselling, etc.)? ☐ Yes ☐ No Explain why. ______
5. In your opinion, is the patient a suitable candidate for a work re-entry program (i.e., ease back, modified duties, gradual return to work, etc.)? ☐ Yes ☐ No Explain why. ______
6. Any additional information or details that may have a significant impact on the patient's recovery from this condition?

______

Signature ______ Date ______

® Saskatchewan Blue Cross is a registered trade-mark of the Canadian Association of Blue Cross Plans, used under license by Medical Services Incorporated, an independent licensee.