

Attending Physician Statement Section

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Policy Number 1PA25

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.