MEDAVIE BLUE CROSS™

ATTENDING PHYSICIAN'S STATEMENT
CRITICAL CONDITION BENEFIT

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3
TEL: 1-800-667-4511 FAX: 1-800-644-1722

Part 1: Patient Authorization

Patient's Name	Date of Birth DD / MM / YY
I hereby authorize the release to my insurer and my policyholder of any information in respect of this application.	
Patient's Signature:	Date DD / MM / YY

Part 2: Attending Physician's Statement

Diagnosis:

A) Primary

B) Secondary

C) Additional conditions or complications

Date symptoms appeared DD / MM / YY	Has patient ever had same or similar condition? ❑ Yes ❑ No If yes, give dates and details:

Date patient first received medical treatment, diagnostic measures, medication, or consultation for this condition.

DD / MM / YY

Date of last treatment for this condition, if different from above. DD / MM / YY	Date of last treatment for this condition. DD / MM / YY
Was patient in hospital? ❑ Yes ❑ No	Name and address of hospital:

Date of hospital treatment

Outpatient: _____ DD / MM / YY **OR** Inpatient Admission: _____ DD / MM / YY Discharge: _____ DD / MM / YY

Surgical treatment, if any: Details:

Date: _____ DD / MM / YY

Are you aware of other physician(s) who treated this patient due to this present condition? ❑ Yes ❑ No
If yes, please give name(s) and address(es):

Do you believe the patient is competent to endorse cheques and direct the use of proceeds? ❑ Yes ❑ No

Please summarize your patient's medical history (attach copies of tests administered including the results of any relevant clinical findings).

List all objective findings:

List all subjective findings:

Please indicate how activities of daily living are affected by this condition.

Eating _____

Dressing _____

Bathing _____

Ambulation _____

Toileting _____

Cardiac functional capacity (if applicable).
(Canadian Cardiovascular Society)

❑ Class 1
No limitations

❑ Class 2
Slight limitations

❑ Class 3
Marked limitations

❑ Class 4
Complete limitations

Please forward results of stress tests, angiogram, etc.

Please outline your prognosis for this patient (refer to the list of critical conditions):

Remarks:

Physician's Name (Print)

Address

Telephone No.
( )

Signature

Date