

# Initial Disability Insurance Medical Statement

The patient is responsible for any fees related to the completion of this form.

Section 1 Patient Information and Consent TO BE COMPLETED BY THE PATIENT			
Patient Name (Last, First, Middle Initial)		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)			
Employer's Name (if applicable)		Contract or Policy #	Certificate # (if applicable)
Date Last Worked (dd/mm/yyyy)		Date Returned to Work or Expected Return to Work Date (dd-mm-yyyy)	
Please list your present medications:			Please provide your:
Name of Medication	Dosage (mg)	How Often?	
1. _____	_____	_____	Height: _____
2. _____	_____	_____	Weight: _____
3. _____	_____	_____	Dominant Hand:
4. _____	_____	_____	Left <input type="checkbox"/> Right <input type="checkbox"/>
5. _____	_____	_____	

I hereby authorize the release of medical and health information in my file to \_\_\_\_\_ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.

I understand that I am responsible for any fees related to the completion of this form. **Medical and health information excludes genetic test results.**

Patient Signature

Date of Consent (dd/mm/yyyy)

Section 2 Medical Statement TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)	
I am the: Family Physician <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____	
<b>PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE</b>	
Diagnosis	
Primary: _____	
Secondary and/or Complications: _____	
If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): _____ Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/>	