

# 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 of Birth (dd-mm-yyyy)																		
Date Last Worked (dd/mm/yyyy)	Date Returned to Work or Expected Return to Work Date (dd-mm-yyyy)																				
Please list your present medications: <table border="1"> <thead> <tr> <th>Name of Medication</th> <th>Dosage (mg)</th> <th>How Often?</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td>_____</td><td>_____</td></tr> <tr><td>2. _____</td><td>_____</td><td>_____</td></tr> <tr><td>3. _____</td><td>_____</td><td>_____</td></tr> <tr><td>4. _____</td><td>_____</td><td>_____</td></tr> <tr><td>5. _____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Name of Medication	Dosage (mg)	How Often?	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	4. _____	_____	_____	5. _____	_____	_____	Please provide your:  Height: _____ Weight: _____  Dominant Hand: Left <input type="checkbox"/> Right <input type="checkbox"/>
Name of Medication	Dosage (mg)	How Often?																			
1. _____	_____	_____																			
2. _____	_____	_____																			
3. _____	_____	_____																			
4. _____	_____	_____																			
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. <b>Medical and health information excludes genetic test results.</b>																					
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>																					
<b>Diagnosis</b>																					
Primary: _____																					
Secondary and/or Complications: _____																					
If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): _____ Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/>																					