

**DISABILITY BENEFITS ATTENDING PHYSICIAN'S STATEMENT CANCER**

To allow us to make an assessment of your patient's claim, please answer all of the questions in full.

**Instructions:**

1. Please PRINT.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

**Part 1: Patient Authorization**

Policy No.:

Name

Date of Birth

DD / MM / YYYY

Address (number, street, city, province and postal code)

Phone Number (include area code)

I hereby authorize the release to Equitable Life of Canada® any information requested by Equitable Life of Canada in respect of this claim.

Patient's Signature

Date

DD / MM / YYYY

**Part 2: Attending Physician's Statement**

1. Diagnosis (including any Complications) please attach a copy of all consultation, operative and pathology reports:

Date of cancer diagnosis:

DD / MM / YYYY

Site of Tumour/Metastases:

Type of tumour:

Grade and staging

2. History (please attach a copy of your clinical notes relating to this period of disability)

Date symptoms first appeared:

DD / MM / YYYY

Has patient ever had same or similar condition?

 Yes No Unknown

If yes, please specify diagnosis and dates of treatment:

DD / MM / YYYY

Describe current symptoms/history:

First visit for these symptoms:

DD / MM / YYYY



8. Is the condition due to injury or sickness arising out of the patient's employment?  Yes  No  
If yes, has your office filed a claim for this condition with the WCB/WSIB on behalf of your patient?  Yes  No
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9. Please indicate your patient's current physical abilities:

Sedentary Duties: Exerting up to 10 pounds (4.5 kg) of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary Duties involve sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

Light Duties: Exerting up to 20 pounds (9.1 kg) of force occasionally and/or up to 10 pounds (4.5 kg) of force frequently, and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Duties. Light Duties usually require walking or standing to a significant degree. However, if the use of the arm and/or leg controls requires exertion of forces greater than that for Sedentary Duties and the worker sits most of the time, the job is rated Light Duties.

Medium Duties: Exerting up to 50 pounds (22.7 kg) of force occasionally, and/or up to 25 pounds (11.3 kg) of force frequently, and/or up to 10 pounds (4.5 kg) of force constantly to move objects.

Heavy Duties: Exerting up to 100 pounds (45.4 kg) of force occasionally, and/or up to 50 pounds (22.7 kg) of force frequently, and/or in excess of 20 pounds (9.1 kg) of force constantly to move objects

Very Heavy Duties: Exerting in excess of 100 pounds (45.4 kg) of force occasionally, and/or in excess of 50 pounds (22.7 kg) of force frequently, and/or in excess of 20 pounds (9.1 kg) of force constantly to move objects.

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In your opinion, what is the earliest date your patient will be able to return to work?	DD / MM / YYYY
If the previous job could be modified, when could rehabilitation employment commence?	DD / MM / YYYY

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10. Please provide the names of other physicians who have been/will be involved in assessing the medical problems; and copies of any available consultation reports.

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11. Do you believe patient is competent to cash cheques and use the proceeds?  Yes  No  
If no, why not?

12. Have you referred the case to the Public Trustee?  Yes  No

We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

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13. Have you completed other requests regarding your patient's current medical condition to other sources, i.e. other insurance providers, Canada Pension Plan, WSIB/WCB, etc.?  Yes  No  
If so, please provide details:

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Name of Physician (please print)

Specialty:

Telephone:

Fax:

Address (number, street, city, province & postal code):

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Physician's signature

Date:

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