



## **ATTENDING PHYSICIANS HOME CARE CLAIMS STATEMENT**

PATIENT NAME \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

I hereby authorize the release to my insurer any information requested with respect of this claim.

DATE \_\_\_\_\_ SIGNATURE OF PATIENT \_\_\_\_\_

### **PHYSICIAN'S STATEMENT**

This form has been specifically designed with the physician in mind. By being comprehensive, it will hopefully reduce the physician's administrative workload. Please complete the sections relating to your patient and stroke out the non-applicable areas. In order to help the claimant, sufficient details of History, Investigation, Findings and Treatment are essential. This form may be mailed directly to the insurer or given to the patient at the physician's discretion.

### **HISTORY**

(a) When did symptoms first appear or accident happen? \_\_\_\_\_ Month \_\_\_\_\_ Day, \_\_\_\_\_ Year

(a) Date home care commenced (if applicable) \_\_\_\_\_ Month \_\_\_\_\_ Day, \_\_\_\_\_ Year

(c) Type of care required and frequency of visits by the Provider \_\_\_\_\_

(d) Date home care terminated \_\_\_\_\_ Month \_\_\_\_\_ Day, \_\_\_\_\_ Year

(e) Full names of other treating physicians \_\_\_\_\_

### **DIAGNOSIS**

(a) Primary

(b) Date of Diagnosis \_\_\_\_\_

(c) Secondary (if applicable)

(d) Date of Diagnosis \_\_\_\_\_

(e) Subjective Symptoms

(f) Objective findings (including results of current X-rays, E.K.G.s or any other special tests)

### **TREATMENT**

(a) Date of first treatment

(b) Date of latest visit

(c) Is patient following recommended treatment program?     Yes     No

(d) Dates of all treatment

(e) Frequency:     Weekly     Monthly     Other (specify) \_\_\_\_\_

**TYPE OF TREATMENT**

- (a) Medications Dosages
- (b) Describe Therapy and projected duration of treatment program
- (c) Type of surgery
- (d) Date of surgery (if applicable)

**PHYSICAL IMPAIRMENT**

Is patient  Ambulatory  Bed confined  House confined  Hospital confined?

Does the patient currently need another person's help in performing any activities of daily living, such as  
 bathing  dressing  toileting  eating  walking indoors  transferring from bed to chair  
 controlling bladder or bowel functions  taking medications as prescribed ?

\_\_\_\_\_  
\_\_\_\_\_

**CARDIAC** (if applicable)

(a) Functional capacity:  Class 1 (no limitation)  Class 2 (slight limitation)  Class 3 (marked limitation)  
 Class 4 (complete limitation)

(b) Blood Pressure latest visit (systolic/diastolic) \_\_\_\_\_

(c) Last METS rating: \_\_\_\_\_ Date of test: \_\_\_\_\_

**VISUAL IMPAIRMENT** (if applicable)

(a) What was vision at latest observation with glasses?

(b) What was vision at latest observation without glasses?

(c) Vision can be restored in whole or in part:  Yes  No If "Yes", by what means?

**PROGNOSIS**

Please indicate date when patient will again be able to perform any of the above activities of daily living

DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHEQUES AND DIRECT THE USE OF PROCEEDS THEREOF?  Yes  No

**REMARKS**

Physician's Name \_\_\_\_\_ Certified Specialist In \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

Date \_\_\_\_\_ M.D. Signature \_\_\_\_\_