Clarica Life Insurance Company / Waterloo, Ontario

Disability Claim - Attending Physician's Statement of Continuing Disability

CLARICA

PLEASE PRINT

This section to be completed by patient (claimant).

Policy/Plan No. 90002B If Group, Section/Division [redacted] Cert. No./ID No. ____

S.I.N. if different from Cert. No./ID No. (Required for Income Tax purposes) ____

Policy/Plan Type ☐ Long Term Disability ☐ Waiver Group Life Ins. ☐ Individual Policy(ies) Date of Birth [redacted] (Day Month Year)

Name ☐ Mr. ☐ Mrs. ☐ Miss ☑ Ms. [redacted] (Last Name) [redacted] (First Name)

I authorize the release of any medical information requested for this claim, to the Clarica Life Insurance Company of Canada, to my Plan Sponsor/Employer and to the Canada or Quebec Pension Plan, for the purpose of administering this benefit claim and this Plan.

Signature of Claimant [redacted] 6 09 2010 (Day Month Year)

Note: The patient is responsible for obtaining this form and for any charges for its completion.

Name of attending physician completing this form LESIUK (Last Name) H. J. (Initials)

☐ Family doctor ☑ Specialist (indicate specialty) Neurosurgery

Physician's Address 1053 Carling (No. & Street) D702 (Suite/Apt. No.) Ottawa (City/Town) ON (Province)

Physician's Telephone No. (613) - 761-5384 (Area Code) Postal Code ____

ATTENTION PHYSICIAN

Complete the sections relating to your patient and stroke out non-applicable areas. To help your patient (the claimant), accurate completion of **both sides** of this form is essential. **Your patient is responsible for the cost of completing this form.** You can mail the form directly to Clarica or give it to the patient at your discretion.

DIAGNOSIS

1. a) Primary [redacted] b) Secondary [redacted]

2. Other contributing factors/complications [redacted]

OBJECTIVE FINDINGS/INVESTIGATIONS

1. You most recently examined this patient 05 08 2010 (Day Month Year)

2. a) Height ____ b) Weight ____ c) Blood Pressure ____ d) Pulse ____

3. Cardiac (if applicable) N/A ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

4. **Physical Limitations** (e.g. range of motion; restrictions on lifting, bending, walking; etc.) Outline any changes since last report
- The main limitation is pain. The pain is constant, even when sedentary but is markedly worse with any activity. The pain is located in the neck, R upper extremity, distal R lower extremity. The

5. **Other Limitations** (e.g. vision, psychological, etc.) Outline any changes since last report
patient is compelled to rest recumbent at regular intervals through the day. In addition to the pain there is:
- numbness R hemibody (partial Brown-Sequard syndrome)
- weakness & clumsiness R hand
- weakness R lower extremity including foot.
(Note: Patient underwent extensive surgery [illegible] passing [illegible] & is still convalescing from that procedure)

6.

Investigations Since Last Report (e.g. EKG's, x-rays, lab tests, etc.)	Date Carried Out	Summary of results (**Attach copies of all available reports.**)

7. Are any further investigations planned? ☐ No ☐ Yes If "Yes", state type and when
Surveillance imaging of C-spine - X-ray, CT, MRI will continue on regular basis.

8. a) Has your patient been referred to any other physicians/specialists? ☐ No ☑ Yes If "Yes", complete the following chart.

Physician's/Specialist's Name	Specialty	Dates of Examinations
Dr. Z. Dhalla	Neurology	ongoing
Dr. G. Johnson	Orthopedic Surgery	ongoing

b) Summarize physician's/specialist's findings As above. - See also previous reports.

TREATMENT

1. Since last report, how often have you seen this patient? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☑ Other *consultation → daily in hospital care*

2. List current medications prescribed and dosage

planned to commence when fusion well established

3. Physiotherapy? ☐ No ☑ Yes If "Yes", frequency ☐ Daily ☐ 3x per Week ☐ Weekly ☐ Other
type ☐ outpatient/physiotherapy dept ☐ independent home exercises

4. Surgery? ☐ No ☐ Yes If "Yes", type of surgery *posterior cervical/thoracic decompression + fusion with instrumentation*
date ☑ performed ☐ planned 15/06/2000 (Day Month Year)

5. Any other treatment or future plans for treatment? (Specify with dates.)

Medications: [redacted]

6. Summarize patient's **response** to treatment

PROGRESS

1. a) Since last report, your patient has ☐ Recovered ☐ Improved ☐ Remained Unchanged ☐ Retrogressed
— patient deteriorated subsequent to last report

b) Give details of any complications, delays in treatment, motivational factors, etc. *with increased pain + [illegible]) [illegible] disclosed at bottom end (?) previous fusion → repeat fusion June [illegible]*

Since surgery there has been some improvement in pain in C8 distribution bilaterally

LIMITATIONS

1. Identify specific medical limitations which prevent your patient from performing his/her **own occupation** (based on your understanding of the duties involved)

2. Identify specific medical limitations which prevent your patient from performing any **other occupation**

The patient has intractable pain barely controlled with [redacted] *(and other meds as noted above) at a sedentary level with frequent periods of bedrest. Any attempt to increase activity at present results in intolerable pain*

PROGNOSIS

Able to return to work at:

1. **Own** occupation ☐ Full-time ___ (Day Month Year) ☐ Part-time ___ (Day Month Year)
☐ Other

2. **Any** occupation ☐ Full-time ___ (Day Month Year) ☐ Part-time ___ (Day Month Year)
☐ Other

disabled indefinitely permanent disability must now be anticipated

3. Would vocational counselling and/or retraining be beneficial now or later? ☐ No ☐ Yes Please comment

N/A

Signature of Physician *[signature]* 08/03/2000 (Day Month Year)