



**Patient's Description of Symptoms**  
 Please describe the patient's current symptoms including frequency and severity:

**Your Clinical Findings and Observations**  
 Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy/Vigour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration/Focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect/Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insight/Judgement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Observations of comments supporting the above:

**Complicating Factors**

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

- Workplace Issues       Social / Family Issues       Financial / Legal Problems
- Physical Condition       Alcohol / Drug Abuse       Medication Side Effects
- Pain Perception       Coping Skills       Personality / Motivation       Other

Please describe:

Please describe the supports in place, or planned, to assist with these issues:

**Investigations**

Please attach copies of all relevant:

- test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - **do not provide genetic test results**
- consultation reports

Are tests / investigations / consultations pending?      Yes       No       Date report expected: (dd/mmm/yyyy)

Does the patient have an appointment booked with any specialist(s) in the near future?      Yes       No

Name of Specialist	Specialty	Date of Appt: (dd/mmm/yyyy)
1. _____	_____	_____
2. _____	_____	_____

Reason for requesting the consultation:

Has any licence held by the patient been restricted or revoked as a result of this condition?      Yes       No       Don't Know

If yes, as of when? (dd/mmm/yyyy) \_\_\_\_\_ Type of licence: \_\_\_\_\_

**Medications** (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mmm/yyyy)	Current dosage and date changed if applicable (dd/mmm/yyyy)	Response

**Hospitalization**

Is/was the patient hospitalized? Yes  No  Is future hospitalization anticipated? Yes  No

Date admitted (dd/mmm/yyyy)      Date discharged (dd/mmm/yyyy)      Institution name

1. \_\_\_\_\_

2. \_\_\_\_\_

**Treatment Details - Psychological**

(e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd/mmm/yyyy)	Frequency of visits	Date of last visit (dd/mmm/yyyy)	Response
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		

**Treatment Details - Concurrent Physiological Disorders, if known**

(e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd/mmm/yyyy)	Frequency of visits	Date of last visit (dd/mmm/yyyy)	Response
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/>		

**Overall Response to Treatment**Please describe the response to treatment to date: Complete  Partial  None  Too soon to tell Is the patient following the recommended treatment program? Yes  No 

Please explain:

Are there any plans to change or augment the current treatment program? Yes  No 

If so, please explain:

**Prognosis and Recovery**

What return-to-work goals have been discussed with the patient? Please explain:

Please provide the patient's prognosis for improvement:

Please provide any other information that will help us understand the patient's current condition, recovery goals and prognosis:

**3 Physician's acknowledgement and authorization**

I acknowledge that the information in this statement will be kept in a disability benefits file with the Manufacturers Life Insurance Company ("Manulife") and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending physician (please print)		Physician's Specialty		Physician's stamp
Address (number, street, suite)				
City	Province	Postal code		
Telephone number	Fax number			
Signature			Date signed (dd/mmm/yyyy)	

**NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.**