ivari™

P.O. Box 4241, Station A
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Critical Illness Attending Physician's Statement

Patient Information

Last name	First name	Date of birth (DD/MM/YYYY)

Address	Apt./suite #

City	Province/territory/state	Country	Postal/zip code

Home phone	Mobile phone	Policy number

ABOUT THE ILLNESS

COMPLETE THIS SECTION FOR ALL CRITICAL ILLNESS CLAIMS AND THE SECTIONS RELATED TO THE SPECIFIC CRITICAL ILLNESS CONDITION

1 Nature of illness or surgery: ______________________

2 Has the patient ever suffered from this or a similar condition? . . . . Yes No

If ***"Yes",*** when: (DD/MM/YYYY) ______________________

3 Date symptoms first appeared: (DD/MM/YYYY) ______________________

4 Description of symptoms: ______________________

5 Date of first consultation for this condition: (DD/MM/YYYY) ______________________

6 Date of diagnosis: (DD/MM/YYYY) ______________________

7 Date patient was informed of diagnosis: (DD/MM/YYYY) ______________________

Name(s) of physician(s) you have referred this patient to or have referred the patient to you:

NAME	CLINIC OR HOSPITAL

Patient History

8 How long has this person been your patient? ______________________ (DD/MM/YYYY) ______________

9 Is there a family history of this condition or any other hereditary illnesses? . . . . Yes No

If ***"Yes,"*** please provide details: ______________________

10 Does the patient use tobacco, nicotine or marijuana products? . . . . Yes No

If ***"Yes,"*** describe the type and daily consumption and how long they have been using them.

____

If ***"No,"*** have they ever used tobacco, nicotine or marijuana products, and if so, when did they stop?

____

11 Has the patient received care, treatment or services, consulted a physician or been prescribed drugs for any illness or any condition(s)? . . . . Yes No

If ***"Yes,"*** provide details:

CONDITION	DATE PATIENT WAS INFORMED OF THE CONDITION (DD/MM/YYYY)	RESULTS

Critical Illness Diagnosis

CANCER

Enclose a copy of the complete medical file, including copies of chart notes, consultation reports, investigations, test results and the pathology report for the biopsy which lead to the diagnosis.

Pathological cancer diagnosis: ______________________

Cancer site: ______________________

Cancer stage: *(I to IV or A to D, as applicable)* ______________________

Is this a recurrence? . . . . Yes No

Date of first occurrence: (DD/MM/YYYY) ______________

Date of recurrence: (DD/MM/YYYY) ______________

Is this a cancer in-situ or is there invasion of tissues? ______________________

Are there lymph nodes involved? . . . . Yes No

Is there metastases? . . . . Yes No

To where? ______________________

HEART ATTACK/MYOCARDIAL INFARCTION

Enclose a copy of the complete medical file, including copies of chart notes, consultation reports, investigations, tests, bloodwork, ECG results, and the hospital discharge summary.

Is this your patient's first myocardial infarction? .... Yes No

If ***"No,"*** date of previous infarction: (DD/MM/YYYY) ____________________

Any rises and falls of biochemical cardiac markers to levels considered diagnostic of myocardial infarction? .... Yes No

Any new electrocardiogram (ECG) changes consistent with a myocardial infarction? .... Yes No

Any new Q waves during or immediately following an intra-arterial procedure, including an angiography, an angioplasty or other procedure? .... Yes No

STROKE/CEREBROVASCULAR ACCIDENT

Enclose a copy of the complete medical file, including copies of chart notes, consultation reports, investigations, test results and the hospital discharge summary.

Is this your patient's first cerebrovascular accident? .... Yes No

If ***"No,"*** date of previous cerebrovascular accident: (DD/MM/YYYY) ____________________

Have any neurological deficits persisted for more than 30 days after the diagnosis? .... Yes No

If ***"Yes,"*** please describe the residual deficits: ____________________

Was the cerebrovascular accident caused by a trauma? .... Yes No

If ***"Yes,"*** please provide details: ____________________

MULTIPLE SCLEROSIS

Enclose a copy of the complete medical file, including copies of chart notes, consultation reports, investigations, test results and the hospital discharge summary.

Has there been two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination? .... Yes No

Has there been well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination? .... Yes No

Has there been a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart? .... Yes No

Was this diagnosis made by a specialist? .... Yes No

OTHER ILLNESS

Enclose a copy of the complete medical file, including test results and the hospital discharge summary.

DIAGNOSIS: ____________________

Description of symptoms, comments or any other information to support this claim:

Please provide any information you feel would be relevant to your patient's claim for critical illness benefits:

Physician Information

Physician's name	Physician's specialty

Address

City	Province/territory/state	Country	Postal/zip code

Phone number (including area code)	Email address

Physician's Signature

Date: (DD/MM/YYYY) ____________

The Claimant is responsible for any fees for this information.

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P.O. Box 4241, Station A, Toronto, ON M5W 5R3 • Telephone: 1-855-806-5057 • **claimsdepartment@ivari.ca**

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