500-5000 Yonge Street
Toronto, ON M2N 7J8
www.ivari.ca

Critical Illness Attending Physician's Statement

Patient Information **PRINT IN INK**

First Name	Middle Initial	Last Name

Address

Phone Number	Policy Number	Date of Birth
		D D / M M / Y Y Y Y

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: D D / M M / Y Y Y Y

3 Date symptoms first appeared: D D / M M / Y Y Y Y

4 Description of symptoms: _____

5 Date of first consultation for this condition: D D / M M / Y Y Y Y

6 Date of diagnosis: D D / M M / Y Y Y Y

7 Date patient was informed of diagnosis: D D / M M / Y Y Y Y

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? _____ D D / M M / Y Y Y Y

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	RESULTS
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	
	D D / M M / Y Y Y Y	

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: D D / M M / Y Y Y Y

Date of recurrence: D D / M M / Y Y Y Y

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: D D / M M / Y Y Y Y

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: D D / M M / Y Y Y Y

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 **PLEASE PRINT**

Physician's Name	Physician's specialty

Address

City	Province	Postal code

Phone Number (including area code)	Fax Number (including area code)

Physician's Signature

Date: D D / M M / Y Y Y Y

The Claimant is responsible for any fees for this information.

500-5000 Yonge Street, Toronto, ON M2N 7J8 • Telephone: 1-800-846-5970 • Fax: 416-883-5715

™ ivari and the ivari logos are trademarks of ivari Canada ULC. ivari is licensed to use such marks.