ivari™

P.O. Box 4241, Station A
Toronto, ON M5W 5R3
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Compassionate Assistance Program – Attending Physician's Statement

To physician: The patient is requesting a benefit payment from their life insurance policy. Your statement is needed to determine the patient's eligibility.

1 Patient's information

Name	Policy number
Address	Date of birth (DD/MM/YYYY)

2 Diagnosis and prognosis

a) Diagnosis of patient's present condition (including any complications):

b) Subjective symptoms:

c) Objective findings (including current x-rays, EKG'S, laboratory data and any clinical findings):

d) In your opinion, is the patient mentally capable of managing his or her property and finances? Yes No

e) Is patient's condition terminal? Yes No

If ***"yes,"*** how long is the patient expected to live? ________ months

3 History

a) When did symptoms first appear or accident happen? (DD/MM/YYYY) ____________________

b) Date patient informed of diagnosis: (DD/MM/YYYY) ____________________

c) Has patient ever had same or similar condition? Yes No

If ***"yes,"*** state when and describe: ____________________

4 Dates of visits

a) Date of first visit: (DD/MM/YYYY) ____________________

b) Date of last visit: (DD/MM/YYYY) ____________________

c) Frequency: weekly monthly other (specify): ____________________

5 Nature of treatment (including surgery and medications prescribed, if any)

6 If referred to you, give name of referring physician

7 Progress

a) Since the date of diagnosis has the patient: improved? unchanged? retrogressed?

b) Is patient: ambulatory? house confined? bed confined? hospital confined?

c) Has patient been hospital confined? Yes No

If ***"yes,"*** confined from (DD/MM/YYYY) ____________ through (DD/MM/YYYY) ____________

Name and address of hospital: ____________

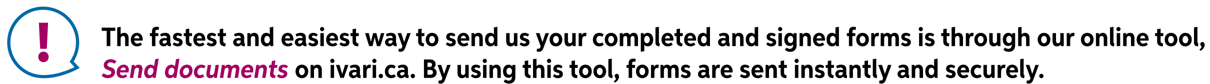
8 Additional comments

Print physician's name	Specialty	
Business address	Telephone	Fax
City	Province	Postal code

I declare that all the statements and answers given above are true, complete and accurate to the best of my knowledge and belief.
I understand that the patient is responsible for securing this form and for charges made for its completion.

Physician's signature ____________ Date (DD/MM/YYYY) ____________

P.O. Box 4241, Station A, Toronto, ON M5W 5R3 • Telephone: 1-800-846-5970 • **claimsdepartment@ivari.ca**



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