ATTENDING PHYSICIAN'S DECLARATION
Long Term Care

- Part 1 must be completed by the patient
- Part 2 must be completed by the physician
- The patient is responsible for any fees charged to have this form completed

To ensure that your patient's claim can be properly assessed, it is important to provide complete answers to all questions.

Part 1 – Identification of Patient

Name: _____ Gender: F ☐ M ☐

Contract No.: _____ Date of Birth: _____-_____-_____
Year Month Day

Part 2 – Physician's Report

1. Diagnosis
   1.1. Primary diagnosis _____ Date: _____-_____-_____
   Year Month Day

   1.2. Secondary diagnosis _____ Date: _____-_____-_____
   Year Month Day

2. Prior consultations
   2.1. Date of last consultation: _____-_____-_____
   Year Month Day

   2.2. Reason for consultation: _____

_____

Note to physician: Please answer questions 3, 4 and 5 based on the following definitions of Activities of Daily Living.

Bathing:
The ability to wash oneself in a bath or shower, including the entering into and exiting from the bath or shower; or by sponge bath.

Dressing:
The ability to put on or take off, and button and unbutton, all requisite clothing, including the putting on of orthopaedic braces, artificial limbs or other surgical accessories.

Transferring:
The ability to move towards a bed, to get into and out of bed and the ability to sit on a chair or a wheelchair and to get up from it with or without the assistance of auxiliary equipment.

Toileting:
The ability to go to the bathroom and return after having taken care of all one's personal hygienic needs.

Continence:
The ability to control bowel and bladder functions voluntarily, with or without surgical appliances or protection from incontinence, in such a way that an acceptable degree of hygiene is maintained.

Feeding:
The ability to eat by oneself the foods and beverages prepared and served by other persons.

The insured is in a **state of dependency** when he or she is usually incapable, **without the assistance of another person**, of performing at least two Activities of Daily Living, or when suffering from a Cognitive Impairment.

3. Please specify which activity(ies) of daily living your patient is usually incapable of performing without the assistance of another person.
   The patient is usually incapable, without the assistance of another person, of:

Bathing: ☐ Yes ☐ No If yes, specify since which date _____-_____-_____ and give details of this incapacity: _____
Year Month Day

_____

Dressing: ☐ Yes ☐ No If yes, specify since which date _____-_____-_____ and give details of this incapacity: _____
Year Month Day

_____

Transferring: ☐ Yes ☐ No If yes, specify since which date _____-_____-_____ and give details of this incapacity: _____
Year Month Day

_____

Toileting: ☐ Yes ☐ No If yes, specify since which date _____-_____-_____ and give details of this incapacity: _____
Year Month Day

_____

Part 2 (cont.)

Continence: ☐ Yes ☐ No If yes, specify since which date _____-_____-_____ (Year-Month-Day) and give details of this incapacity: _____

_____

Feeding: ☐ Yes ☐ No If yes, specify since which date _____-_____-_____ (Year-Month-Day) and give details of this incapacity: _____

_____

Any Activity of Daily Living not mentioned: ☐ Yes ☐ No If yes, specify since which date _____-_____-_____ (Year-Month-Day) and give details of this incapacity: _____

_____

Note to physician: Please answer questions 4, 5 and 6 based on the following definition of cognitive impairment.

Cognitive Impairment means the deterioration of mental capacity demonstrated by the inability to think, perceive, reason or remember. Cognitive Impairment results from Alzheimer's disease and other forms of irreversible senile dementia. Cognitive Impairment must meet all of the following conditions:

1. Be based upon clinical results and standards for measuring the deficiency
2. Have an organic cause
3. Result in a person's inability to care for him or herself without the ongoing supervision of another person

4. Has a Cognitive Impairment been diagnosed? Yes ☐ No ☐

6.1. If yes, please specify diagnosis: _____

6.2. Date of diagnosis: _____-_____-_____ (Year-Month-Day)

6.3. If yes, specify the examinations and tests undergone by the patient to confirm this diagnosis:

1. _____ 2. _____

5. Please check the box that best describes the degree of Cognitive Impairment suffered by your patient. (Check one box only)

☐ The patient has no Cognitive Impairment as defined above.

☐ The patient has a moderate Cognitive Impairment, which requires no supervision.

☐ The patient has a severe Cognitive Impairment, which requires constant supervision to protect the patient from danger to his or her health and safety.

6. Please provide any other information about your patient's Cognitive Impairment not already mentioned in the answers above.

_____

_____

Identification of Physician

Name: _____ Telephone: _____

Licence No.: _____

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: _____-_____-_____ (Year-Month-Day)