

Visitors to Canada Claim Form, Page 2

Attending Physician's Statement

To be completed by the Physician – use a separate form for each condition
(Charges for the completion of this form are the patient's responsibility)

Name of Patient: Last First		Date of Birth: M/D/Y
Reason for Visit/Presenting Complaint:		
Diagnosis of Presenting Complaint:		
Reason for Visit: <input type="checkbox"/> Emergency/urgent care (initial visit) <input type="checkbox"/> Emergency/urgent care (follow-up) <input type="checkbox"/> Check-up <input type="checkbox"/> Renewal of medication <input type="checkbox"/> Healthcare assessment for Immigration purposes		
<input type="checkbox"/> Other, please explain:		
Date of Current Visit:		M/D/Y
When did patient first consult you for this condition?		M/D/Y
Date symptoms first appeared or date of accident:		M/D/Y
If accident, please provide details:		
Will follow-up treatment be required? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide details		
Is patient medically/physically able to return to country of origin after current visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If No, why and when will the patient be fit to travel?		
From patient's case history has he/she ever had the same or similar complaint prior to the first consultation date with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES, please provide details:		
Did another physician treat the patient for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was patient hospitalized for the current condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please provide details (i.e. name of hospital and period of hospitalization):		
Was surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please provide details:		
Was this condition related to the use of alcohol, misuse of drugs or self-inflicted injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was this condition related to pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Physician Certification:

I certify that the information provided in this section is correct and true to the best of my knowledge and belief.

Signature of Physician

Date

Name of Physician (please print)

Specialty

Physician's Stamp:

Physician's Address

Telephone Number