



claims & travel assistance

# EMERGENCY HOSPITAL & MEDICAL INSURANCE FOR CANADIANS MEDICAL CERTIFICATE

**NOTE:** This certificate must be fully completed by the licensed physician at the patient's destination who treated the injury/sickness resulting in this claim. Any fee charged for completing this form is the patient's responsibility.

Patient's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: MM/DD/YYYY Policy #: \_\_\_\_\_

Diagnosis/condition resulting in claim: \_\_\_\_\_

Date of first consultation: MM/DD/YYYY Date symptoms first appeared: MM/DD/YYYY

Date condition diagnosed: MM/DD/YYYY

Has the patient suffered from this medical condition in the past?  Yes  No

If 'Yes', please describe below the patient's history of this condition and other related conditions over the 12 months prior to this visit:

Date of Consultation	Diagnosis	Treatment Rendered
<u>MM/DD/YYYY</u>		
<u>MM/DD/YYYY</u>		
<u>MM/DD/YYYY</u>		

Please list the patient's existing medications prior to the visit: \_\_\_\_\_

Was the condition related to alcohol, misuse of drugs, or self-inflicted injury?  Yes  No If 'Yes', please provide details: \_\_\_\_\_

Was the patient hospitalized?  Yes  No Admission Date: MM/DD/YYYY Discharge Date: MM/DD/YYYY

Name of Hospital: \_\_\_\_\_

Was the visit related to pregnancy?  Yes  No

Date of last Menstrual Period: MM/DD/YYYY Expected Delivery Date: MM/DD/YYYY

Please provide the name and phone number of any other physicians who treated the patient, or referred the patient to you:

Name of other physician: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Name of other physician: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Name of other physician: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

In your opinion, could the treatment for the above condition have been postponed until the patient's return to Canada?  Yes  No

If 'No', please provide medical criteria which would have prevented patient from travelling: \_\_\_\_\_

Please provide the date when the patient would have been able to travel: MM/DD/YYYY

## PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

Physician's Signature: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_

Date: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**PHYSICIAN'S STAMP HERE**