BLUE CROSS® CANASSURANCE

Attending Physician's Statement

Loss of Autonomy Assessment

IDENTIFICATION OF PATIENT (Section to be completed by claimant)

Surname: _____ First Name: _____ Date of Birth: ____ day / month / year ____

Policy No: _____ Public Health Insurance No: _____

ASSESSMENT OF THE LOSS OF AUTONOMY (Please print in block letters.)

1. DIAGNOSIS

1.1. Primary: _____ Onset of symptoms: ____ day / month / year ____

1.2. Secondary: _____ Onset of symptoms: ____ day / month / year ____

1.3. Current symptoms: _____

1.4. Degree of gravity of all symptoms combined: ❑ mild ❑ moderate ❑ severe ❑ with psychotic elements

1.5. Trigger for diagnosis:
❑ accident ❑ illness ❑ abusive consumption of alcohol or drugs ❑ other Please specify: _____

_____

1.6. When was your patient's last visit? _____

1.7. What was the primary reason of that visit? _____

ACTIVITIES OF THE DAILY LIVING (ADLs)

2. ASSISTANCE REQUIREMENT Please complete based on the following definitions of ADLs.

Bathing: washing oneself in a tub or shower or by sponge bath, with or without the aid of equipment.

Dressing: putting on and taking off all necessary items of clothing, including braces, artificial limbs or other appliances.

Toileting: getting to and from the toilet and performing associated personal hygiene.

Continence: managing bowel and bladder functions with or without protective undergarments, so as to maintain a level of personal hygiene compatible with general good health.

Transferring: moving into or out of a bed, chair or wheelchair, with or without the use of equipment.

Feeding: consuming food or drink that has been prepared and served, with or without the use of adaptive utensils.

2.1. Please indicate the degree of assistance required by your patient to perform activities of the daily living as defined above by checking only one box for each activity.

Activities of daily living (ADLs)	No assistance	Some assistance or supervision required	Direct assistance required
Bathing			
Dressing			
Toileting			
Transferring			
Continence			
Feeding			

2.2. When did your patient first require supervision or direct assistance to perform any of the ADLs? ____ day / month / year ____

2.3. Please add any comment that would help us better understand your patient's needs for daily assistance: _____

_____

2.4. Please provide the evaluation report of the occupational therapist.

Note: The claimant must pay any fees requested to complete this form.

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COGNITIVE IMPAIRMENT

3. Please answer the questions based on the following definition of cognitive impairment.

Organic cognitive impairment means mental deterioration and loss of intellectual ability evidenced by a deterioration in memory, orientation and reasoning that is measurable and that results from a demonstrable organic cause diagnosed by a specialist. The cognitive impairment must be severe enough to warrant continuous daily supervision.

3.1. Has your patient been diagnosed with an organic cognitive impairment? ❑ yes ❑ no

If yes, please provide the diagnosis: _____

Onset of the impairment: _____ day / month / year

3.2. Diagnostic tests performed:

1. _____
2. _____
3. _____

Please provide a copy of the evalution report.

3.3. Please specify your patient's degree of cognitive impairment:
- ❑ none
- ❑ mild
- ❑ severe, constant supervision required

3.4. Please provide any other information regarding your patient's ability to perform daily activities. _____

_____

_____

_____

_____

IDENTIFICATION OF THE PHYSICIAN

Surname: _____ First name: _____

Address: _____

_____ Licence No: _____

Telephone: _____ ext.: _____ Fax: _____

❑ Family doctor ❑ General practitioner ❑ Specialist Please specify: _____

Signature: _____ Date: _____ day / month / year

Note: The claimant must pay any fees requested to complete this form.