Acquisition of Medical Information Form

Manulife Financial

Patient Information

Last name	First name	Employee ID#	Home telephone No. ( )
Address	City	Province	Postal Code

Occupational Health Service Information

Case Manager	Medical Counsultant		
Address	City	Province	Postal Code
Telephone No. ( )	Fax. No. ( )		

To be completed by Attending Physician

1. Patient's history of current injury / disease — First Date of Absence (dd/mm/yy)

2. Prior history of similar medical condition

Yes / / No / /

3a. Symptoms and specific physical findings

3b. Please describe any barriers that may preclude an early and safe return to work

4. Diagnosis (es)

a)

b)

c)

d)

If a psychological diagnosis, please provide a DSM IV diagnosis

Axis 1 Diagnosis:

Axis 2 Personality:

Axis 3 Medical:

Axis 4 Family:

Occupational:

Other:

Axis 5 GAF Score:

5. Investigation(s) ordered / with results

6. Describe current or proposed treatment / program including physiotherapy / chiropractic / medication / psychosocial counseling, etc

7. Referral to specialist(s): Name of specialist(s) (please print) — Date of Appointment (dd/mm/yy)

8. Is complete recovery expected?

Yes / / No / /

9. Would transitional / modified work assist in the recovery?

Yes / / No / /

If yes, when should it be considered? (dd/mm/yy)

If no, please state the reason

10. List any medical precautions / recommendations that should be observed when the patient returns to work activities

Expected date for return to full duties (dd/mm/yy)

Physician's name (please print)			
Address	City	Province	Postal Code
Telephone No. ( )	Fax No. ( )	Email	
Physician's signature		Date (dd/mm/yy)	

Please forward your invoice with the attached completed form to the case manager's attention at Manulife.

You will be reimbursed for costs incurred as per your provincial Medical Associations' standard fee guidelines.

Consent (for completion by Employee)

In order to clarify my current medical condition with respect to my work at Canada Post I hereby authorize you to provide the specifc medical information asked for on this form to Manulife Financial

I authorize Manulife Financial and its service providers (collectively "Manulife") to collect, use, and maintain my personal information for the purpose of assessing, investigating and managing my disability claim.

I authorize Manulife to share and discuss with my employer, the status of my claim with respect to information regarding my functional abilities and limitations as well as obstacles to return to work for the purpose of confirming the anticipated duration of my functional limitations and/or my workplace absence, and assisting in my return to work.

Employee's signature	Employee's name (please print)	Date (dd/mm/yy)