Health Status Report:

1. **Please provide factual objective information for all answers.**

Last Name	First Name

Height	Weight	How long have you known this patient?	Indicate the number of visits in the last year by checking the most appropriate box.
6'3"	230lbs	one year	☐ 0 – 5 ☒ 6 – 10 ☐ 11 – 20 ☐ Greater than 20

2. **Please complete the chart below, listing the current and ongoing medical, surgical and/or psychiatric condition(s) of the patient, and the impairment(s) resulting from those conditions. Do not list conditions that have been resolved or are not current or not ongoing within the last year.**

NOTE: For each condition listed below, you must complete all the columns listed (A-F). This section must be completed or the application cannot be processed.

	(A) Condition(s)	(B) Impairment(s)
	Lung Cancer	Shortness of breath
	example	
1.	1° spondylolisthesis	chronic lower back pain
2.	Major depressive episode	Sad and depressed Poor concentration and short term memory Loss of interest in activities
3.		
4.		
5.		

For your reference, the following definitions are provided:

(A) Condition – is the name of the disease or disease state or diagnosis or syndrome.

(B) Impairment – is the loss, loss of use or derangement of any body part or system or function. Function can be psychological or psychiatric in origin.

(C) Restriction – is the limitation to the activities of daily living arising directly or indirectly from the impairment.

(C) Restriction(s)	Duration (D)	Duration (E)	(F) Prognosis of Condition(s)
Cannot walk more than 3 blocks before having to stop. example	**Expected to last:** ☐ less than 1 year or ☒ 1 year or more	**and is** ☐ recurrent/episodic or ☒ continuous	**Is likely to:** ☐ improve ☒ deteriorate ☐ remain same ☐ unknown
Not able to lift over 20lbs or perform repetitive bending movements Not able to maintain static positions for > 30 minutes due to pain	**Expected to last:** ☐ less than 1 year or ☒ 1 year or more	**and is** ☐ recurrent/episodic or ☒ continuous	**Is likely to:** ☐ improve ☐ deteriorate ☒ remain same ☐ unknown
Fatigue limits exercise tolerance, not able to perform sustained activities. Needs memory aids due to poor concentration levels	**Expected to last:** ☐ less than 1 year or ☒ 1 year or more	**and is** ☒ recurrent/episodic or ☐ continuous	**Is likely to:** ☐ improve ☐ deteriorate ☒ remain same ☐ unknown
	Expected to last: ☐ less than 1 year or ☐ 1 year or more	**and is** ☐ recurrent/episodic or ☐ continuous	**Is likely to:** ☐ improve ☐ deteriorate ☐ remain same ☐ unknown
	Expected to last: ☐ less than 1 year or ☐ 1 year or more	**and is** ☐ recurrent/episodic or ☐ continuous	**Is likely to:** ☐ improve ☐ deteriorate ☐ remain same ☐ unknown
	Expected to last: ☐ less than 1 year or ☐ 1 year or more	**and is** ☐ recurrent/episodic or ☐ continuous	**Is likely to:** ☐ improve ☐ deteriorate ☐ remain same ☐ unknown

3. **Please list medication(s) for the current and ongoing condition(s) listed in question No. 2.**

Conditions	Drug	Dosage	Frequency
lower back pain	celebrex	200mg	daily
depression	cipralex	10mg	daily
Anxiety assc.	Ativan	0.5mg	TID prn
with depression			
lower back pain	Tramacet	1-2	QID prn

4. **Please add any other relevant information or comments that you think may be helpful in assessing the applicant's main condition(s) and impairment(s).**

5. **Please list hospitalizations related to the current and ongoing condition(s) identified in question No. 2.**

Name of Hospital	Location (Town)	Dates of admission/date of ER visits (year only) relating to the principal condition(s)	☐ Hospital Report Attached ☐ Discharge Summary Reasons for admission and ER visits and length of stay, if applicable.

6. If there are supporting documents for the condition(s) and impairment(s) listed in question No. 2, please indicate the reason and attach copies. Do *not* send actual x-rays, pathology slides, etc.

- ☐ Laboratory Report(s)
- ☐ Pathology Report(s)
- ☐ Hospital Report(s)
- ☐ Psychological/Psychiatric Assessment
- ☐ Speech Language Pathologist's Report
- ☐ X-ray Report(s)
- ☐ Specialist's Report(s)
- ☐ Discharge Summary(ies)
- ☐ Audiologist's Report/ENT
- ☐ Ophthalmologist's/Optometrist's Report

Please note that the absence of supporting documents, especially consultant's notes, will delay adjudication.

7. Please indicate, and comment on, the management plan(s) for the main condition(s) of impact. More than one treatment may be checked. Please specify dates (month and year is sufficient).

Treatment	Past	Current	Proposed	Comments (specify for which condition)
Medical	☐	☒	☐	
Surgical	☐	☐	☐	
Physical/ Rehabilitation ☐ Physiotherapy ☐ Occupational Therapy ☐ Massage ☐ Chiropractic	☐	☐	☐	
Chemotherapy	☐	☐	☐	
Radiation	☐	☐	☐	
Psychotherapy ☒ Physician ☐ Psychiatrist ☐ Psychologist ☐ Other	☐	☒	☐	
Other (Please indicate) ☐ Counselling ☒ Support Group ☐ Vocational Rehabilitation ☐ Other	☐	☒	☐	

8. Intellectual and Emotional Wellness Scale

▷ ***It is not necessary to complete this area for persons whose conditions are solely of a physical nature.***
For each item indicate the most characteristic class for that item where Class 1 represents no symptoms or signs while Class 2 represents minimal symptoms or signs, Class 3 represents moderate symptoms or signs and Class 4 represents severe symptoms or signs. **Check one choice only.**

Psychologist's/Psychiatrist's report attached ☒ Yes ☒ No **Mark "X" for most appropriate description(s)**	**No assistance from another person is required to complete the activities specified**		**Assistance from another person is required in order to complete the activities specified**	
	Class 1	**Class 2**	**Class 3**	**Class 4**
	• No Symptoms or signs	• Some safety concerns • Minimal symptoms or signs	• Safety concerns • Moderate symptoms or signs	• Unsafe • Severe symptoms or signs
A Bodily functions (eating, eliminating, sleeping)	☐	☒	☐	☐
B. Consciousness (attentional focus, levels of consciousness)	☐	☒	☐	☐
C. Emotion (affect, mood, anxiety and other emotions, associated psychological disturbances, panic phobia)	☐	☒	☐	☐
D. Impulse control (difficulty with behavioural control)	☒	☐	☐	☐
E. Lack of insight (grandiosity, excessively negative self evaluation, difficulty in understanding one's own mental health problems)	☒	☐	☐	☐
F. Intellectual function (cognitive disturbance, planning, organizing, sequencing and abstracting difficulties)	☐	☒	☐	☐
G. Judgement (difficulties anticipating impact of one's behaviour on self and others)	☒	☐	☐	☐
H. Learning (language processing, mathematics, attention difficulties)	☐	☒	☐	☐
I. Memory (amnesia, hypervivid flashback, dissociation)	☒	☐	☐	☐
J. Motivation (depressive avolitional problems)	☐	☒	☐	☐
K. Motor behaviour (conversion, motor coordination deficit, agitation, retardation and compulsions)	☒	☐	☐	☐
L. Perception (visual processing, hallucination, illusion, dissociation, sensory distortions, pain amplification)	☒	☐	☐	☐
M. Thinking (delusions, obsessions, flight of ideas, blocking)	☒	☐	☐	☐

Visual/Ophthalmological Impairments:

9. **Only complete this area for persons who have a contributing ophthalmological or visual impairment. The visual fields section may not apply in every case. If not appropriate to your patient, you may leave it blank.**

Complete Snellen Visual Acuity Chart

	Uncorrected		Corrected	
	Near	**Distance**	**Near**	**Distance**
Right Eye				
Left Eye				
Both Eyes				

☐ Report from Optometrist, Ophthalmologist attached.

Visual Field Defect

If there is a visual field defect component in the patient's visual disability, please send a copy of your clinical data documenting the field loss (Humphrey's preferred).

Ocular Mobility

A. Diplopia

If there is diplopia in any direction of gaze, please report:

1. The direction in which the diplopic occurs.
2. The location in degrees from the primary position.

B. Change in Habitual Phoria (heterophoria/strabismus/eye movements)

If there is a change in the habitual phoria that results in either a prismatic correction or a restriction in the type of appliance that can be utilized (e.g. contact lenses), please supply the clinical data documenting the change.

Ocular Adnexa

Are there any permanent deformities of the orbit, such as scars, cosmetic defects, etc. that alter function?

Auditory/Hearing Impairments:

☐ Audiogram attached

10. Only complete this area for persons who have a hearing problem of any significance.

1. How and when did the person's hearing loss begin?

2. Is the hearing loss unilateral or bilateral?

3. In the patient's mother tongue or first language, does he/she encounter difficulty understanding speech in a quiet environment?

4. Does the patient encounter difficulties understanding conversational speech in the presence of background noise?

5. Is the patient able to hear warning sounds, like sirens, car horns, and smoke detectors?

6. Are there safety concerns related to hearing? (Unable to localize sound or direction of approaching vehicles, etc.)

7. Does the patient have a constant, annoying ringing (tinnitus) in his/her ears?

8. Has there been a change in hearing loss over the last 5 years? If so, how?

9. Does the patient wear hearing aids?

10. With hearing aid(s), could or can the patient function normally?

Please fill out this page if you are completing the Health Status Report *only*.
If you are completing both the Health Status Report and the Activities of Daily Living Index, please fill out the page at the end of the package.
The application will *not be* processed if the appropriate page is incomplete.

Please complete the following in BLOCK LETTERS.

Name

Address

Telephone No. 705-

Fax No.

Stamp

E, ONTARIO

Certificate of Approved Professional

I, _____

am a legally qualified _____ physician _____ in the **Province of Ontario**

and this report contains my clinical assessment and considered opinion at this time.

_____ Feb 17 2011

Signature Date

Activities of Daily Living Index:

Classification for Activities of Daily Living Index:

Applicant's Name *(please print)*

Date of Birth

Day | Month | Year

The Activities of Daily Living Index may be completed by the following persons who are registered with their respective college: physicians, psychologists, psychological associates, ophthalmologist, optometrists, registered nurses in the extended class (RNEC), registered nurses, occupational therapists, physiotherapists, audiologists, speech language pathologists, chiropractors, and social workers.

If the approved professional completing the Activities of Daily Living Index is someone other than the person completing the Health Status Report, please list the current and ongoing medical, surgical and/or psychiatric conditions for which the Activities of Daily Living Index is being completed.

These questions *must* be completed for all clients.

These questions seek to describe the impact of the impairment on the applicant's ability to attend to his or her personal care, function in the community and function in a workplace. It seeks to understand the restrictions in the activity specified. Please use the scaling below:

Class 1	Class 2	Class 3	Class 4
Within normal limits. **Or** Not applicable. **Note:** Does not prevent the performance of any activity.	Mild or slight limitations. **Note:** May result in slightly longer time requirements to complete the task or mild exacerbation of pain. **Or** Accommodation may be required to complete the task.	Medium or moderate limitations. **Or** Requires considerably longer time to complete the task and may on some occasions be unable to complete the task with or without accommodations and with or without moderate pain.	Severe or complete limitations on most occasions to completion of the task.

		Mark an "X" through choice			
1.	Orientation to time, person and place	①	②	③	④
2.	Recognizes within normal limits common dangers in the home, workplace or community	①	②	③	④
3.	Ability to comprehend, express or communicate orally	①	②	③	④
4.	Use the telephone	①	②	③	④
5.	Exhibits normal limits of functioning with respect to intelligence	①	②	③	④
6.	Exhibits normal limits of functioning with respect to impulse control and behaviour	①	②	③	④
7.	Responds within normal limits to situations requiring memory (e.g. remember where he/she lives, names of family and friends, etc.)	①	②	③	④
8.	Attention span is sustainable and appropriate to task	①	②	③	④
9.	Physical strength commensurate with person's age and sex	①	②	③	④
10.	Ability to participate physically in sustained activity	①	②	③	④
11.	Walks three blocks or more on level ground without need to rest	①	②	③	④
12.	Climbs up or down one flight of stairs (six steps)	①	②	③	④
13.	Able to use means of public transport if available	①	②	③	④
14.	Wash all parts of the body, able to maintain personal hygiene and grooming	①	②	③	④
15.	Select clothes for weather and situations	①	②	③	④
16.	Bowel and bladder control	①	②	③	④
17.	Can take medication(s) as directed and handle/store medication(s) safely	①	②	③	④
18.	Is able to utilize commercial services (banks, hydro, phone company, etc.)	①	②	③	④
19.	Financially responsible for his/her own affairs (e.g. applicant can function independently)	①	②	③	④
20.	Able to feed oneself	①	②	③	④
21.	Do housekeeping (cleaning, laundry, meal preparation, shopping for essentials such as groceries, clothes, etc.)	①	②	③	④
22.	Able to stand	①	②	③	④
23.	Able to sit for a sustained period	①	②	③	④
24.	Able to transfer to and from chair, toilet, wheelchair, etc.	①	②	③	④