MEDICAL REPORT

SECTION A To be completed by Applicant

First Name and Initial	Last Name
Home Address (No., Street, Apt. No., P.O. Box, R.R.)	City, Town or Village

Province or Territory	Country	Postal Code
Telephone number	Date of Birth (Year Month Day)	Canadian Social Insurance Number

SECTION B To be completed by Physician

Please provide factual objective opinions

1. Height Weight	2 a) How long have you known the patient?	b) When did you start treating the patient for the main medical condition? Year Month	c) Date of last visit Year Month Day

3. Diagnosis(es)

4. Relevant/significant medical history relating to the main medical condition:

Please write legibly

Service Canada delivers Human Resources and Skills Development Canada programs and services for the Government of Canada.

5. Over the past two years, has the patient been admitted to a hospital/institution?

☐ Yes **If yes,** please list:

☐ No

Name of the Hospital(s)/Institution(s)

The date(s) of admission Year Month Day	The reason(s) for admission
_____	_____
_____	_____
_____	_____

6A. Is there supporting evidence for the main medical condition? Please attach supporting documentation.

Laboratory Reports	☐ Yes	☐ No
X-ray reports	☐ Yes	☐ No
Consultants' opinions	☐ Yes	☐ No
Other	☐ Yes	☐ No
Documentation to be returned	☐ Yes	☐ No

6B. Please describe relevant physical findings and functional limitations.

Please write legibly

7. Are further consultations or medical investigations planned relating to the main medical condition?

☐ Yes **If yes,** please specify:

☐ No

8. Is the patient currently on medication(s) as a result of the main medical condition?

☐ Yes **If yes,** please indicate dosage and frequency.

☐ No

9. Treatment: List type and response.

Please write legibly

Canadian Social Insurance Number

FOR OFFICE USE ONLY		
☐ A.C.	Initials	Year Month Day

10. Prognosis of the main medical condition of this patient:

11. Additional Information

SIGNATURE (Please print or use a stamp)

Physician's Full Name

Address

Postal Code

☐ Family Physician

☐ Specialty _____

Signature X	Year Month Day	Telephone No.

Please write legibly