Musculoskeletal Questionnaire
Attending Physician's Statement

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping information concerning this claim confidential.

PLEASE PRINT CLEARLY IN INK

Sun Life Financial

To be completed by member

Member's Name _____ Date of birth: |__|__|__|__|__|__|__|__|
First and last name (Quebec residents - maiden name) Day Month Year

Policy/Contract No. _____ Member ID |__|__|__|__|__|__|__|__|__| Control No. _____

AUTHORIZATION: I authorize my doctor to use and exchange information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that a photocopy or electronic version of this authorization is as valid as the original.

Signature of claimant _____ **Date** |__|__|__|__|__|__|__|__|
Day Month Year

Note: The patient is responsible for any cost associated with the completion of this form.

To be completed by attending physician

Diagnosis and history:

Primary: _____ Frequency of symptoms: _____

Secondary: _____ Frequency of symptoms: _____

1. Have you been supervising this patient's care? ❑ Yes ❑ No

   If no, please explain _____

2. Frequency of visits: ❑ Weekly ❑ Bi-weekly ❑ Monthly ❑ Other _____

3. Date of last visit |__|__|__|__|__|__|__|__| Day Month Year Date of next scheduled visit |__|__|__|__|__|__|__|__| Day Month Year

4. Has your patient had the same or similar condition in the past? ❑ Yes ❑ No ❑ Unknown

   If yes, state when and describe the condition: _____

   _____

5. ❑ Right handed ❑ Left handed (if applicable to illness/injury)

6. Weight _____ Height _____ In a weight reduction program? ❑ Yes ❑ No

Describe your patient's current complaints: _____

_____

_____

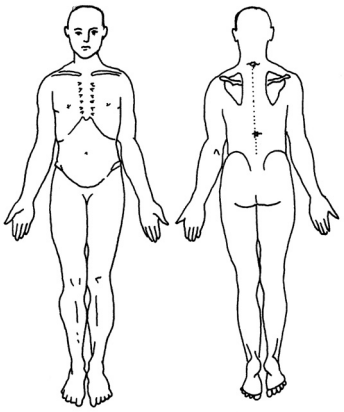
Please complete if appropriate : Has the patient been referred to a specialist ❑ Yes ❑ No
If no, please explain.

_____

Clinical findings - range of motion

Circle affected joint(s) and/or muscle group(s)

(Note: Specify findings if more than one joint is involved)



Please provide applicable ROM findings (in degrees):

Flexion: _____

Lateral flexion: _____

Extension: _____

Internal rotation: _____

External rotation: _____

Abduction: _____

Adduction: _____

Rotation: _____

Supination: _____

Pronation: _____

Grip strength: _____

Straight leg raising: Sitting: Lt. _____ Rt. _____

Lying: Lt. _____ Rt. _____

Neurological findings

		Comments
Weakness present:	❑ Yes ❑ No	
Muscle wasting noted:	❑ Yes ❑ No	
Decreased sensation or numbness present:	❑ Yes ❑ No	
Reflexes:	❑ Normal ❑ Diminished ❑ Absent	

Investigative findings

Tests (e.g. scans, x-rays, lab tests)	Date performed Day Month Year	Summary of results **(Attach copies of all available reports)**

Are there any further investigations planned: ❑ Yes ❑ No

If yes, indicate when and the type _____

Functional evaluation

1. Indicate degree of impairment from pre-disability functioning:

	None	Slight	Moderate	Severe
Cognition	❑	❑	❑	❑
Sensation	❑	❑	❑	❑
Dexterity	❑	❑	❑	❑
Driving	❑	❑	❑	❑
Walking	❑	❑	❑	❑
Standing	❑	❑	❑	❑
Climbing	❑	❑	❑	❑
Sitting	❑	❑	❑	❑
Reaching:				
above shoulder	❑	❑	❑	❑
below shoulder	❑	❑	❑	❑
Squatting	❑	❑	❑	❑
Bending	❑	❑	❑	❑
Lifting	❑	❑	❑	❑

2. What tests were conducted to determine the severity/degree of impairment?

_____

_____

_____

_____

_____

3. Your patient can lift/carry a maximum of:

Kgs:	0	5	9	14	18	23	27	32	36	41+
Lbs:	0	10	20	30	40	50	60	70	80	90+

4. Please comment on any additional medical conditions, complications or motivational factors (etc.) that may affect your patient's ability to return to work.

_____

_____

_____

_____

_____

Patient's name _____

Treatment

1. List current medications prescribed and dosage:

_____

_____

_____

2. Who else is treating your patient? Name of Physician/provider Treatment prescribed/frequency

_____

_____

_____

3. Surgery? ❑ Yes ❑ No If yes, indicate the type of surgery _____

Date performed Day Month Year Date planned Day Month Year

4. Is your patient following recommended treatment program? ❑ Yes ❑ No

If no, please comment _____

5. Any other treatment or future plans for treatment? (ie. Medication changes, tests, therapy etc. Please specify dates)

_____

_____

6. Summarize your patient's response to treatment: _____

_____

_____

_____

7. Does the patient demonstrate pain behaviour? ❑ Yes ❑ No If yes, please comment on impact to recovery. _____

_____

_____

8. Is your patient attending a pain management program? ❑ Yes ❑ No If yes, provide program details _____

_____

_____

Prognosis

Have you discussed a return to work plan with your patient? ❑ Yes ❑ No

If no, why not?

_____

If yes, please provide details about the return to work plan, including time frames.

_____

_____

Expected date of return to work full time Day Month Year

Notice to physician

Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the claimant or in harm to a third party.

Physician/clinician name _____ Specialty _____

Physician signature_____ Date Day Month Year

Physician / Specialist address_____

Tel #_____

Fax #_____

Return this form to your patient or send the form to Sun Life Assurance Company of Canada Disability Management office. If you fax or mail the form to, please confirm the appropriate Disability Management office with your patient. Thank you for your assistance.

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