Dilated Cardiomyopathy

Physician's Statement (Specialist only)

PLEASE PRINT

Name of patient: _____ _____

Surname First Name Date of Birth (mm/dd/yy)

Address: _____

Number & Street City Province Postal Code

Telephone ( ) _____

1. Please provide the diagnosis of your patient's condition?

_____

_____

2. What is the cause of your patient's condition?

_____

_____

3. When did your patient first experience symptoms (mm/dd/yy)? _____

4. When was your patient referred to you (mm/dd/yy)? _____

5. When did you see your patient for this condition (mm/dd/yy)? _____

6. When was the diagnosis made (mm/dd/yy)? _____

7. Please provide copies of all echocardiogram reports.

8. Is this impairment likely to be permanent? ❒ Yes ❒ No

9. Using the standard Bruce protocol if applicable, to what stage of a treadmill exercise test is your patient able to progress?

_____

_____

_____

10. Please provide copy of any/all treadmill tests.

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236 Carlton St, Winnipeg, Manitoba R3C 1P5
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Email: WawanesaLife-claims@wawanesa.com
wawanesalife.com

11. Is your patient's physical activity limited due to their condition? ❒ Yes ❒ No

If Yes, please provide details of the degree of physical limitation.

12. Please provide details of any other specialists that your patient has been seen by in connection with this condition.

13. Please provide details of treatment given/planned.

14. Has the patient previously suffered from the same or related condition? ❒ Yes ❒ No

If Yes, please provide full details including dates.

15. Are you aware of any misuse of alcohol or drugs in your patient's history? ❒ Yes ❒ No

16. Have any of the patients family members suffered from cardiovascular disease? ❒ Yes ❒ No

If Yes, please state the relationship to the patient, the condition and the age of diagnosis.

Name (Please print) | Degree

Street Address | City | Province | Postal Code

Area Code & Telephone Number | FAX number

Date (mm/dd/yy) | Signature

M
D

This form is to be completed by a physician licensed in Canada whose practice is limited to the particular branch of medicine relating to the applicable critical illness. The INSURED is responsible for the completion of this form without expense to the Company.

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