



Fenchurch Claims Centre

Supplemental Medical Information Request

Dear Doctor,

The information provided through this submission will be used in the adjudication of your patient's claim for disability benefits. Please answer all questions as clearly and completely as possible. Incomplete or illegible entries may delay or negate future payment of benefits. Please attach additional sheets as required.

FGIC will pay the costs associated with the preparation of this report per the provincial schedule of fees.

Thank you in advance for your time and attention to this matter.

Patient Information

First Name:

Last Name:

Date of Birth:

Employer:

Occupation:

To Be Completed By Attending Physician (Please Print Clearly)

Primary Diagnosis (for psychiatric diagnosis include DSM-IV GAF):

Axis I –

Axis II –

Axis III –

Axis IV –

Axis V –

Secondary Diagnosis:

Objective Findings:

Subjective Findings:

When did symptoms first appear?

Date of first visit:

Date of last visit:

Frequency of visits: Weekly Monthly Other

Has your patient undergone surgery Yes No

If yes, please give date, describe procedure and result:

Will your patient undergo surgery in future? Yes No
If yes, please give date and describe procedure to be performed:

What medication(s) is your patient currently taking or been prescribed?

Please indicate other types and frequencies of treatments:

Current Medical Status

Please include any changes made in your patient's treatment plan and any complications.

- Improved
 Unchanged
 Worse

Comments:

Diagnostic Procedures and Tests

Please specify any tests that have been completed or are scheduled – provide copies of all reports and/or test results.

Referrals

Please provide copies of any specialist consultation and/or progress reports.

Referral to:
Referral to:
Referral to:

Specialty:
Specialty:
Specialty:

Functional Limitations and Return to Work Planning

Please provide detailed information re: physical and/or cognitive limitations to working:

Is your patient able to return to full work and regular hours at this time? Yes Yes – with limitations No

If No, what is the estimated time frame/date before he/she may return to work?

Mailing and Faxing Information

Fax or Mail the completed form and test results to:	Fenchurch Claims Centre 104-2071 Kingsway Port Coquitlam, BC V3C 6N2	Fax Number 1.888.473.5949
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Physicians Signature

Date

Physicians Name/Specialty/License Number

Telephone Number

Fax Number