7. Please indicate your patient's current physical abilities:

☐ Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

☐ Light Duties: require frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

☐ Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.

☐ Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

List physical restrictions and tolerances: _____

In your opinion, what is the earliest date your patient will be able to return to work?

Year _____ Month _____ Day _____

If the previous job could be modified, when could rehabilitation employment commence?

Year _____ Month _____ Day _____

8. Please provide the names of other physicians who have been/will be involved in assessing the medical problems; **and copies of any available consultation reports.**

was sent to St Paul's Hospital See By Neurologist Dr Yeaser

9. **Hospitalization** if applicable for this illness or injury

Date of in-patient admission: Year _____ Month _____ Day _____

Date of discharge: Year _____ Month _____ Day _____

Date of out-patient treatment: Year _____ Month _____ Day _____

Name of hospital: _____

10. **Surgery**

Surgical procedure performed: _____

Date of surgery: Year _____ Month _____ Day _____

Name of surgeon: _____

11. We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

Due to patient falling asleep frequently when driving & while working & symptom of severe depression, he is unfit to work. He will be going to MEXICO where he has needs family support. He will be consulting doctor in MEXICO (*)

Name of Physician (please print) N. T. TONG

Specialty FP

Telephone: DR N.T. TONG Fax: _____

Address (number, street, city, province & postal code): 25422

SEAFAIR MEDICAL CENTRE
16 - 8671 No. 1 Road
Richmond, B.C. V7C 1V2
Tel: 275-5155 / 275-5166

Physician's signature _____ Date 25 Mar 09

(*) Period of disability - unknown presently

ATTENDING PHYSICIAN'S INITIAL STATEMENT
LONG TERM DISABILITY INCOME BENEFITS

This is not a request for examination but for information taken from your chart. The patient is responsible for securing this form and any charges for its completion.

Name of Patient: VICTOR BERNARDO VENEGAS GWL Employee Identification: 55

Name of Employer: BEE-CLEAN Policy Number: 232583

I hereby authorize the release of any information requested on this form to The Great-West Life Assurance Company or any of its agents.

Date: NOVEMBER 25 '04 Signature of Patient:

1. **History**

   Date symptoms first appeared ~~or accident happened~~: Year 2004 Month 11 Day 10

   Has patient ever had the same or similar condition? ☒ Yes ☐ No

   If yes, please specify diagnosis and dates of treatment.

2. **Diagnosis** (including any complications)

   Primary Major Depression + Post Traumatic Stress disorder

   Secondary Obstructive Sleep Apnea

   Subjective Symptoms: Insomnia Hypersomnolence Poor Memory Flashback memory Falls asleep frequently Periodic tears + anxiety

   Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings): **Please attach a copy of your clinical notes relating to this period of disability.**

3. Current Height _____ Current Weight _____

4. In your opinion, when did the patient's condition first prevent him/her from working?

   Year 2004 Month NOV Day 10

5. **Treatment**

   Date of first visit: Year 2004 Month 11 Day 10

   Date of latest visit: Year 2004 Month 11 Day 25

   Frequency of visits: ☐ Weekly ☐ Monthly ☒ Other

   If other, please specify 0 ± 3-5 days

   What is the current treatment regimen? (drug dosage, physio, other and progress)

   PROZAC 20mg o/d

   need to see Psychiatrist

6. Is the condition due to injury or sickness arising out of the patient's employment?

   ☐ Yes ☒ No

   If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? ☐ Yes ☐ No

Referral Request

Avecina Medical Clinic

#100-20644 Fraser Hwy
Langley, BC
V3A 4G5
Tel: (604) 539-1744
Fax: (604) 539-1755

Refer to:
Dr. DR

Specialized in: Psychiatrist

Tel: _____

Fax: _____

Address: _____

_____

Patient's Name: Victor Venegas

Patient Phone #: _____

DOB: _____

PHN: _____

Appointment date and location: _____

Patient informed on Date: _____

Reason for Referral:

depression
anxiety
difficulty sleeping

PMH:

isolation

Medications:

Referred by: Dr. E. Fasihy MSP #: 27443

Attached documents:

Aug 10

Referral Request

Avecina Medical Clinic

#100-20644 Fraser Hwy
Langley, BC
V3A 4G5
Tel: (604) 539-1744
Fax: (604) 539-1755

Refer to:
Dr. Richard Neufeld

Specialized in: Psychn.

Tel:

Fax:

Address:

Patient's Name: Victor Vanegas

Patient Phone #:

DOB:

PHN:

Appointment date and location:

Patient informed on Date:

Reason for Referral:

depression
anxiety
losing job.
isolating himself

PMH:

Medications:

Referred by: Dr. E. Fasihy MSP #: 27443

Attached documents:

Asgio