

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 ARMANDO VENEZAS GWL Employee Identification: 55

Name of Employer: BEE-CLEAN Policy Number: 232883

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 25 104 Signature of Patient: [Signature]

1. History

Date symptoms first appeared <sup>re-</sup> 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 Persistent Stress & 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 day

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

PROZAC 20mg qd  
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

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 Pauls Hospital See By Neurologist  
Dr Jensen*

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 & symptoms of severe depression, he is unable 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): \_\_\_\_\_

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

Physician's signature \_\_\_\_\_ Date *25 July*

*Ⓢ period of disability - unknown presently*

Referral Request  
Avecina Medical Clinic

#100-20644 Fraser Hwy  
Langley, BC  
V3A 4G5

Tel: (604) 539-1744  
Fax: (604) 539-1755

Refer to:  
Dr.   *M*    
Specialized in:   *Psychiatrist*  

Patient's Name:   *Victor Venegas*    
Patient Phone #: \_\_\_\_\_

Tel: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

DOB: \_\_\_\_\_  
PHN: \_\_\_\_\_

Appointment date and location: \_\_\_\_\_

Patient informed on Date: \_\_\_\_\_

Reason for Referral:

*depression*  
*anxiety*  
*difficulty coping*

PMH:

*isolated breast*

Medications:

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

Attached documents:

*Agrio*

**Referral Request  
Avecina Medical Clinic**

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

Refer to: Richard Perrot  
Dr.         

Patient's Name: Victor Venegas

Specialized in:         

Patient Phone #:         

Tel:         

DOB:         

Fax:         

Address:           
        

PHN:         

Appointment date and location:         

Patient informed on Date:         

Reason for Referral:

*depression, anxiety,  
105mg J<sub>06</sub>,  
isolebin, amitriptyline*

PMH:

Medications:

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

Attached documents:

*Perrot*