



6.12 - Medical Release and Report

Protected (when completed) to be handled by authorized personnel only

Page 1 of 2

Client Details

Last Name	First Name
Band Name	Family Number
Birth Date	Department or Band Administrative Authority Ermineskin Assisted Daily Living

Health problem as reported by client:

Authority to Release Information (to be completed by client)

I, _____ of Ermineskin Cree Nation
Name First Nation Community
In the Province of Alberta give permission to any Physician who has medical information about me to release
it to the First Nation Income Support Program in Ermineskin Assisted Daily Living when requested.
Information about my
First Nation Community
health and a medical opinion is provided so that my ability to participate in employment, pre-employment,
training, and rehabilitative measures can be determined.

Client Signature

Date

Message to the Physician

1. The person named above authorizes the disclosure of medical information to the First Nation Income Support Program in Maskwacis, Alberta. It will be used in connection with the administration of Income Support Benefits and may be provided to the client.
2. The Physician may be contacted to provide additional medical information.
3. The information in this report will assist in determining the client's availability for employment, pre-employment, or rehabilitation measures.
4. There is a basic fee for the completion of this report. If it is necessary to examine the client especially for this report the Physician may also charge the equivalent to Alberta Medical Association (AMA) negotiated fee for the examination.
5. **Payment will be made to the Physician upon receipt of the Physician's original invoice and satisfactorily completed report. The invoice and report can be mailed to the address below:**

Issuing Authority Name: Ermineskin Assisted Daily Living

Phone Number: 780-585-3478

Date Medical Report Requested:

Fax: 780-585-3894

Address: Ermineskin Assisted Daily Living Program
Box 219
Maskwacis, Alberta T0C 1N0

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Page 2 of 2

Medical Assessment (to be completed by Physician). Additional sheets may be attached if required.		
Primary Health Problem (specify) _____	___ severe ___ moderate ___ mild	Date of Onset _____
Secondary Health Problem (specify) _____	___ severe ___ moderate ___ mild	Date of Onset _____
Additional Health Problem(s) (specify) _____	___ severe ___ moderate ___ mild	Date of Onset _____
With Treatment will the condition(s) ___ worsen ___ remain the same ___ improve ___ unpredictable	Is substance abuse a factor in the patient's health problem? ___ yes ___ no	If yes, describe the problem and type of treatment(s).

Prognosis	
Duration of Medical Condition ___ permanent ___ temporary (duration) _____ ___ uncertain ___ episodic	How often is this patient required to access medical services per month? (e.g. appointments, physiotherapy, testing, counselling) Number of times per month: _____ Number of months: _____
What type of treatment is being recommended?	
Is the patient following the recommended treatment? ___ yes ___ no	
If the patient is in the hospital expected release date is _____	

Abilities			
The Patient is able to undertake:			
Physically demanding work (lifting up to 45.5 kg, carrying up to 23 kg etc)	full time	part time	not at all
Medium work (lifting up to 23 kg, carrying up to 9 kg etc)	full time	part time	not at all
Sedentary / Light work (lifting up to 4.5-9 kg, carrying up to 4.5 kg)	full time	part time	not at all

Limitations		
Identify possible limitations to employment, pre-employment, training, and rehabilitation measure caused by the medical condition or treatment:		
Vision ___ severe ___ mild ___ none	Hearing ___ severe ___ mild ___ none	Memory ___ severe ___ mild ___ none
Comprehension ___ severe ___ mild ___ none	Speech ___ severe ___ mild ___ none	Walking ___ severe ___ mild ___ none
Standing ___ severe ___ mild ___ none	Bending ___ severe ___ mild ___ none	Using Stairs ___ severe ___ mild ___ none
Sitting ___ severe ___ mild ___ none	Other (specify) _____	Special Diet (specify) _____

Summary		
Medically fit for employment now ___ yes ___ no	If no, date medically fit for employment _____	Medically able to attend training or rehabilitative program ___ yes ___ no

Certification of Examining Physician	
I, _____ am a Physician specializing in _____	
Print Name	GP or Speciality
Have examined the patient and this report contains my findings and considered opinion at this time.	
I have been the Patients Physician for: ___ six month or less or ___ over six months.	
Physician's Signature	Date
Address:	