

**Physician's statement**

Last name of patient:

First name of patient:

Date of birth:  /  /  Phone number:

day / month / year

**Please detail in case of dismemberment**

1- Please attach the test results and a copy of your clinical notes and consultation reports.

Diagnosis \_\_\_\_\_ Date of the diagnosis  /  /

day / month / year

Date of the accident (if applicable)  /  /    Date of the amputation  /  /

day / month / year

2- Please detail the specific joint level of the amputation and indicate on the following diagram.

\_\_\_\_\_


3- What was the date of the patient's first visit for his/her current condition?  /  /

day / month / year

4- Please detail the nature of treatments provided to this patient.

\_\_\_\_\_

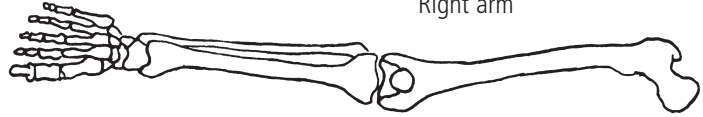
**Please indicate the site of amputation**



**Limb loss**

Date  /  /


day / month / year



Right arm

Date  /  /


day / month / year



Right leg

Date  /  /


day / month / year



Left leg

Date  /  /

day / month / year

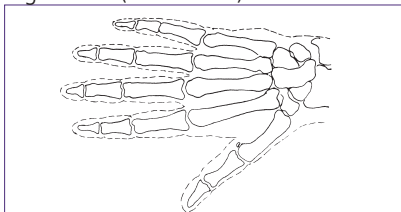


Left arm

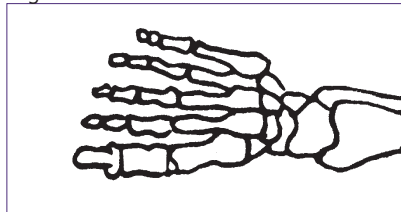
Date  /  /

day / month / year

Right hand (dorsal view)



Right foot





**To complete if there was loss of use**

5- Total or definitive loss of use, please check the appropriate boxes.

Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leg	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quadriplegia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paraplegic	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemiplegia	<input type="checkbox"/> Yes <input type="checkbox"/> No		

6- Total or definitive loss of use, please check the appropriate boxes.

Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right eye	<input type="checkbox"/> Left eye		
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right ear	<input type="checkbox"/> Left ear	Is it a congenital condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No

7- Can vision, speech, or hearing be partially or completely covered by a device or a rehabilitation program?  Yes  No

**If yes**, specify \_\_\_\_\_

8- Is loss solely attributable to the above-mentioned condition or accident?  Yes  No

**If not**, specify any other cause at the origin of the loss:  
 \_\_\_\_\_  
 \_\_\_\_\_

**To be completed if there has been loss of vision (please attach the report of the ophthalmologist)**

9- Loss of vision

Did the accident cause a total loss of vision?  Yes  No

If yes, the loss affects:

- The both eyes
- The right eye only
- The left eye only

Date of loss of vision:

day	/	month	/	year		

In your opinion, the vision can be improved?  Yes  No

If yes, indicate how:

- By a treatment
- By an operation
- By wearing glasses

Is this loss permanent?

Yes  No

Please indicate what was the visual acuteness of the insured **before the accident**:

Right eye \_\_\_\_\_

Left eye \_\_\_\_\_

(Scale of Snellen)

Please indicate what is the **current** visual acuteness of the insured:

Right eye \_\_\_\_\_

Left eye \_\_\_\_\_

(Scale of Snellen)

**To be completed if there has been loss of hearing (please attach the results of the audiogram)**

10- Was there loss of hearing?  one (1) ear  two (2) ears

Hearing loss: low frequency limit \_\_\_\_\_ decibel

high frequency limit \_\_\_\_\_ decibel

Frequency used in the audiogram (for calculating averages): \_\_\_\_\_ hertz

11- Is this loss considered as total?  Yes  No

**If yes**, since which date

day	/	month	/	year	

12- Is this loss permanent?  Yes  No

The \_\_\_\_\_ 20 \_\_\_\_\_ M.D.

Print name

Signature

Address

Phone No.