

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient. Patient is then to return the completed form with his/her accident claim form to the office of the sport he/she was injured in, at 200 Main St., Winnipeg, MB, R3C 4M2. Any inquiries, contact Sport Manitoba Inc., 925-5604.

PATIENT'S NAME: _____ AGE: _____

ADDRESS: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

If brace is required, explain the medical necessity (be specific): _____

If hospitalized, give name of hospital: _____

Date Admitted: _____ 20 ____ Discharged: _____ 20 ____

If referred to you, give name of referring physician:

Operations (or other procedures performed:)

_____ Date: _____

_____ Date: _____

_____ Date: _____

Date of first consultation for above: _____ 20 ____

Date of first symptoms: _____ 20 ____ Date of Accident: _____ 20 ____

Has the patient ever had same or similar condition? _____

If "Yes", please state when and describe: _____

Is there any other disease or infirmity affecting the present condition?

Date: _____ 20 ____ Signature: _____ (M.D.)

Address: _____

Certified Specialist: _____ Phone: _____