



THE DISTRICT OF THUNDER BAY
SOCIAL SERVICES ADMINISTRATION BOARD

MEDICAL INFORMATION FORM

To be completed and submitted to Children's Services Division no later than: _____

TO: _____
(Physician's Name)

I, _____, in accordance with *Section 31 (a) and 31 (b)* of the
(Recipient's Name)

Municipal Freedom of Information and Protection of Privacy Act, hereby authorize and direct you to release to The District of Thunder Bay Social Services Administration Board, Children's Services, the information requested below.

DATED at _____, this _____ day of _____, 20__.

(Recipient's Signature)

PATIENT'S NAME: _____

ADDRESS: _____

Postal Code

PHONE: _____

1. Is this person a regular patient of yours? Yes No (circle one)

2. Please indicate the significant/relevant conditions and diagnoses for which this patient is being treated.

3. Briefly describe the nature of the treatment proposed/being rendered (include the place and period of relevant hospitalization).

4. What is your prognosis for your patient's condition?

5. In your opinion, do any of these conditions restrict this patient from caring for his/her child(ren)? Yes No (circle one)

If yes, please complete the type of child care needed: (check one)

Full Days (6+ hours)/Full-time (5 days/week) _____
Part Days (< 6 hours)/Full-time (5 days/week) _____
Part Days (< 6 hours)/Part-time (< 5 days/week) _____

6. Do you expect sufficient improvement to take place in the health of this patient to allow him/her to:

a) Return to his/her employment Yes No (circle one)

 If yes, when? _____ (date)

 Full-time ___ Part-time ___ (check one)

b) Care of his/her child(ren): Yes No (circle one)

 If yes, when? _____ (date)

 Full-time ___ Part-time ___ (check one)

Signature of Attending Physician: _____

Name of Physician: _____

Address: _____

Date: _____