Shirley
Keesick

19-Jun-1957

DR. INGVES

Attending Physician Statement

(Please take full package to your physician)

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INITIAL ATTENDING PHYSICIAN'S STATEMENT GENERAL FORM

A PLEASE PRINT.
B PART 1 to be completed by patient.
C PART 2 to be completed by physician.
D Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)	Policy or group or contract no.	Certificate or identification no.	Date of birth
KEESICK SHIRLEY	641028		1957 06 19

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including complications) - If psychiatric, give DSM-IV code.

1.1 Primary: Right 2nd toe non-healing infected wound and gangrene

1.2 Secondary: Diabetes, left leg wound, chronic kidney disease

1.3 Subjective symptoms (including severity, frequency, duration): Tenderness to the wound

1.4 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings):

1.5 Degree of severity of all symptoms: ☐ Mild ☑ Moderate ☐ Severe ☐ With psychotic elements

2. History

2.1 Date symptoms first appeared or accident happened: 2022 12 10

2.2 Date patient's condition first prevented them from working: 2023 02 17

2.3 Has this patient ever had same or similar condition? ☐ Yes ☑ No ☐ Unknown

If yes, please specify diagnosis and dates of treatment:

2.4 Is condition due to injury or sickness arising out of patient's employments? ☐ Yes ☑ No ☐ Unknown

2.5 Have Worker's Compensation/CSST forms been completed? ☐ Yes ☑ No ☐ Unknown

2.6 If patient is pregnant, give E.D.C.: YYYY MM DD

2.7 Names and specialties of other treating physicians: diabetes specialists

2.8 Current height: 5' 5" Current weight: 177 lbs Weight loss/gain to date:

3. Treatment dates

3.1 Date of first visit for current condition: 2023 02 17

3.2 Date of latest visit: 2023 03 02

3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): admitted to hospital

3.4 Date of in-patient admission: 2023 02 17

3.5 Date of discharge: YYYY MM DD

3.6 Date of out-patient treatment: 2023 03 21

3.7 Name of hospital: Thunder Bay Regional Health Sciences Centre

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): Piptaz, Vancomycin daily x 2 weeks

4.2 Surgeries (including dates): Right second toe amputation (Feb 21st)

4.3 Other (including frequency): Wound care, diabetes education, nephrology consult.

4.4 Is patient following recommended treatment program? ☑ Yes ☐ No (please elaborate):

5. Progress

5.1 Has patient: ☐ Recovered ☑ Improved ☐ Not improved ☐ Retrogressed
5.2 Current status: ☑ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

6. Restrictions and limitations

			HOURS AT ONE TIME					TOTAL HOURS DURING THE DAY				
			< 1	< 1-2	< 2-4	4-6	6-8	< 1	< 1-2	< 2-4	4-6	6-8
6.1	Stand	☑ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.2	Walk	☐ No restriction no weight bearing right	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.3	Walk on uneven surfaces	☑ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.4	Sit	☑ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.5	Drive	☐ No restriction no driving	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.6	This patient can lift/carry a maximum of:	kgs	(0)	5	9	14	18	23	27	32	36	41+
		lbs	0	10	20	30	40	50	60	70	80	90+
6.7	☐ No restriction	☐ Repetitively: how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐ Occasionally: how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6.8 Please indicate in the space provided if this patient is able to perform the following actions: Frequently (F), Occasionally (O), or Not at all (N):
Drive: N Bend: F Squat: N Kneel: N Climb: N Reach (above shoulders): O Reach (below shoulder): O

7. Psychiatric illness (if applicable) N/A

7.1 History: _____
7.2 Precipitating chronological events: _____
7.3 Work issue related to this illness: _____
7.4 Pre-morbid personality: _____
7.5 Changes in ADL habits: _____
7.6 Familial risk factors: _____
7.7 Progress with treatment plan: _____
7.8 Are patient's symptoms related to drug or alcohol abuse? ☐ Yes ☐ No
If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility: _____
7.9 Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state when: YYYY MM DD

8. Return to work plans

8.1 Prognosis for improvement or recovery: improvement / recovery ~ 6 weeks
8.2 Expected date patient will return to their own occupation: 2023 04 ~~03~~ 11 - modified duties (mx)
8.3 If unknown, please indicate the next follow up date: YYYY MM DD
8.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work: _____
8.5 Have return to work time lines been discussed with the patient? ☑ Yes ☐ No
8.6 Please elaborate on time frames and patient's response: we are both in agreement, will also depend on healing progress.

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): ☐ Yes ☐ No N/A
If yes, please specify: _____
9.2 Is patient a suitable candidate for vocation rehabilitation? ☑ Yes ☐ No If yes, please specify: if needed

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?
Reassess driving in 4-6 weeks

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT): INGLES MATTHEW
11.2 Specialty: SURGEON (VASCULAR) License no.: 100493
11.3 Address - No., street, suite: 200 - 1040 Oliver Rd City: Thunder Bay Province: ON Postal code: P7B 7A5
11.4 Telephone no.: (807) 345 - 5036 Fax no.: (1888) 504 1696
Signature of physician: _____ Date: 02/03/23

Thunder Bay Regional Health Sciences Centre | Thunder Bay Regional Health Research Institute

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6000
www.tbrhsc.net

2-23-2023

Patient name: Shirley Keesick

DOB: 19/06/1957

Address: Box 114, 105 Detta Rd. Balmerotown, ON P0V 1C0

To whom it may concern:

This patient was admitted at the Thunder Bay Regional Health Sciences Centre since 17-02-2023. She will be here for an undetermined amount of time. Dr.Matthew Ingves has approved of patient requiring to be off of work for six weeks. Patient to return to work on April 11th, 2023.

M Ingves

Gloria Boshkaykin – gloria boshkaykin
Indigenous Care Coordinator
Anishnawbe Mushkiki/TBRHSC
807-630-9379
807-684-5887