BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

MEDICAL REPORT
CHILD

SR Number

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act.* The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act.* For any questions concerning the collection, use or disclosure of this information, please contact the ministry.

A - PERSONAL INFORMATION (Dependent Child, CIHR, Foster Child, Out of Care, Kith and Kin)

Last Name	First Name	Middle Name

File Number	Personal Health Number

B - AUTHORITY TO RELEASE INFORMATION (Completed by Parent / Guardian)

I am the guardian of the child named above. I consent to the medical practitioner named below disclosing medical information about the child named above, as requested in this form, to the ministry. The information will be used by the ministry in assessing my employability and eligibility for an earned income exemption.

Signature of Parent / Guardian	Signature of Witness	Date Signed (YYYY MMM DD)

C - MEDICAL ASSESSMENT - To be completed by a Medical Practitioner (Please Print)

All questions must be answered completely in order for the ministry to determine how a child's physical or mental condition affects the parent's/caregiver's employability. Incomplete information may result in the parent/caregiver not being accurately assessed. The contents of this report are confidential, but are subject to the following conditions:

- the report will be shared with the Recipient;
- the report will be shared with the Employment and Assistance Appeal Tribunal if an appeal is initiated.

1. Physical or Mental Condition of the Child:

a. Primary condition: _____ Date of Onset (YYYY MMM DD) _____

b. Secondary condition: _____ _____

c. How would you describe the overall severity of the condition(s)? mild ☐ moderate ☐ severe ☐

2. Prognosis:

a. Expected duration of condition(s): Number of weeks: _____ months: _____ or years: _____

If more than 2 years, please provide additional comments: _____

b. Condition(s) is episodic in nature: Yes ☐ No ☐

i) How frequently have the episodes occured? _____

ii) How frequently are they likely to recur? _____

3. Care Required:

Describe (qualitatively and quantitatively) the assistance or supervision the child requires during a typical week as a result of the physical or mental condition(s). (e.g., personal care, mobility, administering medications, etc.) (attach additional pages if required)

_____

_____

4. Certification

I, _____ am a physician registered with the College of Physicians and Surgeons of British Columbia and licensed to practice clinical medicine in BC.

☐ I am a general practitioner

☐ I am a specialist in _____

This report contains my findings and considered opinion at this time. I have been the patient's medical practitioner for:

☐ 6 months or less ☐ Over 6 months

If 6 months or less ☐ I have examined previous medical records

☐ I have not examined previous medical records

Address including postal code (stamp or print)

Payment:
The fee for completing this form may be billed through MSP on Fee Item 96505.
The Fees for Health Professionals and Service Providers rate table is available at gov.bc.ca/bcea/ratetables

Date (YYYY MMM DD)	Signature of Medical Practitioner

Medical Practitioner Number	Telephone