

1. Does your patient take Lasix or other diuretic? yes no If yes, what dosage? _____
 If so, for what condition? CHF HTN Peripheral Edema Other (please specify): _____
2. Does your patient take an ACE-inhibitor? yes no
 If so, for what condition? CHF HTN Other (please specify): _____
3. List any other therapy required during the past 3 years (e.g. home oxygen, chemo, radiation therapy, etc.).
 Therapy: _____ Date (or period of treatment): _____
 Therapy: _____ Date (or period of treatment): _____
 Therapy: _____ Date (or period of treatment): _____
4. List all hospitalizations during the past 3 years.
 Date of hospitalization: _____ Diagnosis: _____
 Date of hospitalization: _____ Diagnosis: _____
 Date of hospitalization: _____ Diagnosis: _____
5. List all major tests and investigations during the past 2 years (e.g. cardiac stress test, cardiac catheterization, scans). *Please include a copy of the test results.
 List other recent significant tests (e.g. Hgb for anemia, creatinine for renal insufficiency, LFTs for cirrhosis, etc.).
 Test/investigation: _____ Date: _____ Results: _____
 Test/investigation: _____ Date: _____ Results: _____
 Test/investigation: _____ Date: _____ Results: _____
 Ejection fraction (if known): _____ % Date: _____ Smoking status: yes no
6. Is the patient awaiting investigations, surgery or any other treatment?
 yes no If so, please specify the type and the date: _____
7. Has your patient ever undergone a Coronary Artery Bypass Graft? yes no Date (m/y) _____
 Angioplasty? yes no Date (m/y) _____
 Stenting? yes no Date (m/y) _____
8. Has the patient ever had a functional cardiac classification for Angina? ... yes no
 If so, what is the patient's CURRENT class of Angina? ... I II III IV Date of last episode (d/m/y): _____
9. Has the patient ever been diagnosed or treated for Congestive Heart Failure? yes no
 If so, what is the patient's CURRENT class of Congestive Heart Failure? ... I II III IV Date of last episode (d/m/y): _____

Part D COMMENTS

Part E PHYSICIAN INFORMATION

How long has the applicant been your patient? Since (d/m/y)? _____ Are you this patient's family physician, specialist or other? _____

Physician's name: _____ Address: _____

Prof. No.: _____ Telephone: _____ Fax: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

THIS FORM MUST BE RETURNED TO: **INGLE Insurance: Fax: 416-730-1878 Mail: 460 Richmond Street West, Ste 701, Toronto On, Canada, M5V 1Y1**