



Medical Report: Summary Information

Client Identification:

Surname: (provide alias or AKA names in brackets)

Forename/First Names:

Physician:

Full name:

Address :

Telephone number:

DMP Number:

Place of examination:

Print Summary:

Section A

Client Identification & summary

Section B

Functional Inquiry, Background Information
and Applicant's Declaration

Section C

Examining Doctors' s Finding's

Section D

Laboratory Requisition

Section E

Chest X-Ray Report



Citizenship and Immigration Canada / Citoyenneté et Immigration Canada

**Medical Report: Section A
Client Identification & Summary**

Visa Office & Number:
IMS Serial Number:
FOSS Client ID:

Surname: (provide alias of AKA names in brackets)					Forename/First Names		
Date of Birth	Day	Month	Year	Country of Birth	Sex	Marital Status	PHOTO PHOTOGRAPH OF APPLICANT Required for all applicants. Must be taken within six months of the medical examination
Mailing Address (for use if further medical information is required)					Category of Applicant		
					Intended Canadian Destination		
Telephone Number: ➤							
Contact Address/Person within Canada (name, full address and telephone number)							

PHYSICIAN'S SUMMARY AND DECLARATION BASED ON HISTORY AND PHYSICAL EXAMINATION
 ✓ check off ALL appropriate item(s):

- A. Findings that are unremarkable or minor conditions** which normally respond well to short term office/outpatient treatment. SURGERY IS NOT REQUIRED. Applicant can be followed by a general practitioner and will have minimal requirements for hospitalization or social services. NO ACTIVE TB OR DANGEROUS BEHAVIOUR. (e.g. NORMAL CHILDREN, controlled diabetes and/or hypertension with no associated significant end organ damage, cataracts not requiring immediate surgery, psychiatric disorders that are well controlled and where the applicant is capable of working and will likely remain self-sufficient, etc.)
- B. Findings that require periodic specialist follow-up care** but which normally can be handled without resorting to repeated hospitalizations or the provision of social services (e.g. totally asymptomatic congenital or rheumatic heart disease where the requirement for hospitalization and/or surgical intervention appears unlikely over the next 10 years, well controlled rheumatoid arthritis with a minimal functional impact, etc.) Applicant should be able to function independently and be self-sufficient (no anticipated need for domiciliary or nursing home care in the future). No evidence of mental retardation or developmental delay. NO ACTIVE TB OR DANGEROUS BEHAVIOUR. At most only minor hospitalizations.
- C. Findings that may require more extensive investigations or care. Applicants where:**
 - (1) HOME/INSTITUTIONAL SUPERVISION & CARE is needed,
 - (2) MAJOR OR RECURRENT HOSPITALIZATIONS are likely, (especially for procedures involving joint replacements, transplantation, cardiac surgery, subspecialist care, etc.),
 - (3) SPECIALIZED HOSPITAL FACILITIES such as DIALYSIS units, CANCER outpatient clinics,
 - (4) There is a need for use of intermittent/continuing SOCIAL SERVICES, or SPECIALIZED EDUCATION/VOCATIONAL TRAINING,
 - (5) DETERIORATION appears likely,
 - (6) The normal acquisition or maintenance of SELF-SUFFICIENCY APPEARS DOUBTFUL,
 - (7) ACTIVE TB appears to be present (or an easily communicable serious infectious disease),
 - (8) BEHAVIOUR appears to be POTENTIALLY DANGEROUS to others (e.g. some psychiatric disorders or illicit drug/alcohol abuse during the last two years, especially when associated with impaired driving or legal difficulties).
- D. Other conditions/disorders** difficult to categorize OR where there is a lack of sufficient medical information.

ALSO MARK HERE IF APPLICANT IS CURRENTLY A REFUGEE/REFUGEE CLAIMANT

DECLARATION: I declare that I have confirmed the identity and examined this applicant and that this is a true and correct record of my findings.					
Physician's full name, address and telephone number (OFFICE STAMP MAY BE USED)					
Signature	Date	Day	Month	Year	Place of examination



Medical Report: Section B

Functional Inquiry, Background Information and Applicant's Declaration

**APPLICANT (or guardian) to answer in the presence of the examining physician.
IF YOUR ANSWER IS YES TO ANY OF THE FOLLOWING QUESTIONS, PROVIDE DETAILS INCLUDING DATES.**

HAVE YOU EVER HAD or NEEDED: Provide details below, continue on reverse if needed.

1. An operation/ HOSPITAL treatment for any reason	No	Yes >		
2. Convulsions, blackouts, loss of consciousness, "fits" or EPILEPSY ?	No	Yes >		
3. Anxiety, depression or NERVOUS PROBLEMS requiring treatment?	No	Yes >		
4. High blood pressure, any HEART trouble, CHRONIC COUGH , breathlessness or chest pain?	No	Yes >		
5. Recurrent or CHRONIC PAIN in the neck, back, or any joint sufficient to interfere with work or normal day-to-day activity?	No	Yes >		
6. Problems with DIGESTION , stomach pains, heartburn, blood in stool, chronic diarrhea?	No	Yes >		
7. TUBERCULOSIS , a SEXUALLY TRANSMITTED DISEASE , or any other COMMUNICABLE DISEASE lasting more than 3 weeks?	No	Yes >		
8. A history of jaundice or HEPATITIS involving you OR anyone in your immediate family?	No	Yes >		
9. A history of KIDNEY or bladder disease or complaint?	No	Yes >		
10. DIABETES or history of sugar in the urine?	No	Yes >		
11. Any OTHER ILLNESS , injury or medical condition lasting more than 3 weeks or a recurring condition not previously mentioned? Any recent UNINTENTIONAL WEIGHT LOSS ?	No	Yes >		
12. Are you taking any pills, MEDICATION or receiving any medical treatment?	No	Yes >		
13. Have you ever been ADDICTED to alcohol or a drug, or taken drugs illegally?	No	Yes >		
14. Have you ever had a test indicating the presence of the HIV virus or have you ever been told that you were suspected of having AIDS , HIV INFECTION , or any other immune disorder?	No	Yes >		
15. Are you eligible for or do you receive a PENSION for MEDICAL/PSYCHOLOGICAL reasons?	No	Yes >		
16. AUTISM , MENTAL RETARDATION , DEVELOPMENTAL DELAY or other physical or mental DISABILITIES/IMPAIRMENTS affecting your current or future ability to function independently?	No	Yes >		
17. Any medical, psychological, alcohol related, or other TREATMENT in the past 5 years?	No	Yes >		
18. Are you PREGNANT ? If so, what is the expected date of delivery:	No	Yes >	Date	Year
19. Previously, have you undergone a Canadian Immigration medical examination for any reason (whether completed or not)? If so, where, when and under what name?	No	Yes >		

List all countries (with duration of stay) where you have lived during the last five years:

Last country of permanent/long term residence prior to landing in Canada:	Occupations/activities in last 5 years:
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Intended length of stay:	Months	Years	Intended occupation/activity in Canada
A. <input type="checkbox"/> Permanent/long term B. <input type="checkbox"/> Temporary for			

Declaration and Authorization of applicant (or guardian)

I hereby declare that the information I have provided is true and complete. I authorize any physician, laboratory, clinic or hospital to release to the Department of Citizenship and Immigration any information concerning my health or medical history. I also authorize the Department to release information obtained for the purpose of this immigration medical examination to a public health agency or a physician in Canada, if indicated. I certify that the information I have provided on this form is correct.

Applicant's Signature >	Date	Day	Month	Year



Medical Report: Section C Examining Doctor's Findings

- Review answers provided by applicant in Section B and provide details if needed.
- The physical examination of organ systems should be preceded by an appropriate functional inquiry.
- If at any time there is **ANY** clinical or radiologic finding suggestive of active TB, immediately refer to an appropriate specialist and submit a specialist's report.
- In keeping with standard ethical practice, the applicant should be made aware of abnormalities detected, in particular conditions requiring early or urgent intervention.

1. Weight / Height (crown-heel length for infants)		_____ kg	_____ cm	Comments on abnormalities (continue on back of this sheet if needed)
Head Circumference: Include an appropriate specialist report if clinically abnormal. PROVIDE ACTUAL HEAD MEASUREMENT FOR INFANTS ≤ 18 MONTHS OLD:		_____ cm	Normal Abnormal	
Hearing (able to hear whispered voice at 6 metres/20 feet)		Normal	Abnormal	
Eyes (include funduscopic exam / red reflex as appropriate) Provide a specialist report for presence or history of cataract, trauma, glaucoma, or other eye condition or disease.		Normal	Abnormal	
Corrected Visual Acuity If necessary, use pin-hole occlusion. Provide appropriate comments for those too young to be tested. Provide a specialist ophthalmologist's report where the corrected visual acuity is abnormal (worse than 6/12 in either eye)		_____ Lt.	Normal Abnormal	
		_____ Rt.	Normal Abnormal	
2. Ear, Nose, Throat, Mouth, Teeth		Normal	Abnormal	
3. Endocrine System		Normal	Abnormal	
4. Skin, Lymph Nodes, and Breasts (Inspect skin for cancer, leprosy, surgical scars, and tattoos. Inspect neck, axilla, and groin for lymphadenopathy)		Normal	Abnormal	
5. Cardiovascular System (e.g. evidence of heart failure or other heart / vascular abnormalities, RHYTHM DISTURBANCES , abnormal bruits, TACHYCARDIA . Describe all murmurs and clearly comment if they are felt to be functional or pathologic)		Normal	Abnormal	
Blood Pressure (required for all applicants aged 15 and older): Systolic _____ Diastolic _____ Include a SERUM CREATININE and CARDIOLOGIST'S REPORT if repeated readings after rest are abnormal and exceed the following limits: 59 years of age or less 140 / 90 60 years and over 160 / 90		Normal	Abnormal	
6. Respiratory System (consider smoking history, chronic/recurrent lung conditions, cardiopulmonary disorders etc.) If there is a history of TB provide full details and enclose all available old chest X-ray films Provide Respiratory Rate: _____ Breaths/minute If this applicant SMOKES , how many pack-years? _____ pkg.-years		Normal	Abnormal	
7. Gastrointestinal System (include a RECTAL EXAM if appropriate)		Normal	Abnormal	
8. Urogenital System If clinically appropriate, females should be asked to provide evidence of a recent Pap smear result from their own physician or gynaecologist. Include a PROSTATE EXAM if appropriate.		Normal	Abnormal	
9. Locomotor System / Physical Build		Normal	Abnormal	
10. Indication of any substance abuse?		Normal	Abnormal	

11. Nervous System Sequelae of stroke or cerebral palsy, other neurologic disabilities	Normal	Abnormal	Comments on abnormalities (continue on back of this sheet if needed)	
A) Is there any evidence of DEVELOPMENTAL DELAY? (Examples include the following: (i) infants not speaking their first word before 12 months of age, (ii) infants not speaking in two or three word sentences before 2 1/2 years of age, (iii) infants failing to walk independently before 16 months of age).	No	Yes		
B) Do you think there is ANY MENTAL RETARDATION?	No	Yes		
C) After the acquisition of appropriate English or French communication skills, is it likely that the applicant will require further SPECIAL ASSISTANCE at school AND/OR special vocational training? Is there anything to prevent this applicant from acquiring such skills?	No	Yes		
D) Is there ANY evidence of DEMENTIA (Making NO adjustments for age)? Review all applicants for cognitive function to determine if short, medium, or long term memory deficits exist. Formal testing using Folstein's Mini-Mental Examination (or local equivalent) is recommended as appropriate.	No	Yes		
Special Questions of Concern				
12. Is there any Physical or Mental condition which may affect this person's ability to earn a living, take care of themselves or adapt to a new environment, now or in their future adult life? Document these physical or psychiatric conditions.	No	Yes		
13. Is there any personal / family history of a condition which might reasonably lead to the requirement, now or in the future, for Organ Transplantation or Dialysis? (e.g. diabetic / lupus nephropathy, pyelonephritis, family history or personal history of polycystic kidney disease, chronic active hepatitis or hepatitis carrier state)	No	Yes		
14. Has applicant ever received treatment or follow-up for any type of Cancer? (if yes, provide up-to-date details & staging)	No	Yes		
15. Concerning this applicant, on average: i) How many days per week is alcohol consumed: _____ days/week ii) How many drinks per week does this applicant consume: _____ drinks/week iii) What is the maximum number of drinks consumed on any one occasion during the last two months: _____ drinks Do you feel this applicant is at increased risk for developing Alcohol-Related Problems , is currently experiencing alcohol-related problems (abuse), or is alcohol dependent?	No	Yes		
16. During the last 2 years , has this applicant been in close contact with anyone who had active tuberculosis or any type of tuberculosis requiring treatment?	No	Yes		

Summarize abnormalities and provide your opinion as to **PROGNOSIS**. If full mobility and physical self-sufficiency is in doubt enclose an 'Activities of Daily Living Form' or local equivalent:

DECLARATION: I declare that I have confirmed the identity and examined this applicant and that this is a true and correct record of my findings.					
Examining physician's name, address and telephone number (OFFICE STAMP MAY BE USED)					
Signature	Date of examination	Day	Month	Year	Place of examination



Medical Report: Section D Laboratory Requisition

Surname		Forenames (First Names)			PHOTO PHOTOGRAPH OF APPLICANT Required for all applicants. Must be taken within six months of the medical examination.
Applicant's Declaration: I authorize any physician, laboratory, clinic or hospital to release to the Department of Citizenship and Immigration any information obtained for the purpose of this immigration medical examination to a public health agency or a physician in Canada, if indicated.					
Applicant's Signature		Date	Day	Month	

1. Perform the investigations requested below.
2. Person collecting blood or receiving specimen should sign in the corresponding signature box below to confirm that the sample was collected from the individual identified above.
3. Please return this form to the ordering physician.

	Urinalysis Required: Age 5 yrs and older	Signature
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DIPSTICK FOR PROTEIN, GLUCOSE AND BLOOD. If abnormal, do a microscopic urinalysis (clean specimen).
If urinalysis is known to be unremarkable & normal, check here →

	Syphilis Serology Required: Age 15 yrs and older	Signature
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If syphilis serology is known to be nonreactive / negative, check here →

	Serum Creatinine See below for indications	Signature
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SERUM CREATININE is required for applicants with hypertension, diabetes, auto-immune disorders, a confirmed abnormal urinalysis done on a repeat clean specimen, and those with a history of urinary tract disorders or disorders potentially affecting renal function

	24h Urine for Total Protein Indicated if 1+ protein or more on urinalysis	Signature
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	Hepatitis B surface antigen When indicated	Signature
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	HIV When indicated	Signature
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	Sputum smears and cultures for TB When indicated (collected over 3 days)	Signature
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		Signature
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Medical Report: Section E CHEST X-RAY REPORT

- A ROUTINE chest X-ray is required for all aged 11 years and older. A chest X-ray is also required for those under 11 years of age if there is any relevant history or clinical indication (e.g. history of TB involving any part of the body, previous contact with active TB, congenital/chronic heart/lung conditions etc.). **THE CHEST X-RAY FILM REMAINS THE PROPERTY OF THE DEPARTMENT OF CITIZENSHIP AND IMMIGRATION.**
- The chest X-ray must be on a large posteroanterior (PA) film and must bear the date of the examination, the applicant's surname and given names, and the Canadian Immigration file number (if available). **Names must be written in the ENGLISH ALPHABET.** This information is to be automatically inscribed during the photographic process or written in ink (preferably white ink). **If the examinee is pregnant, the film must be full sized, the field size must be strictly limited and there must be abdominal shielding.**
- This report is to be returned to the Physician who examined the applicant.

1. Applicant Details						
Surname		Forenames (First Names)				PHOTO PHOTOGRAPH OF APPLICANT Required for all applicants. Must be taken within six months of the medical examination.
Applicant's Declaration: To be signed by the applicant (or responsible guardian) in the presence of the radiographer/technologist.						
I hereby declare that the information I have provided is true and complete. I authorize any physician, laboratory, clinic or hospital to release to the Department of Citizenship and Immigration any information concerning my health or medical history, including X-ray films. I also authorize the Department to release information obtained for the purpose of this immigration medical examination to a public health agency or a physician in Canada, if indicated.						
Applicant's Signature		Date	Day	Month	Year	
2. Certification: (If X-ray deferred, provide reason below and return form to examining physician)						
If deferred provide reason:						
DECLARATION: (IF X-ray is NOT deferred): I certify that I have carried out the X-ray of the person whose photograph and signature are on this form.						
Writing Address and telephone number of location where chest X-ray was taken (please print or use office stamp)						
Signature of Technician / Radiographer		Date chest X-ray taken	Day	Month	Year	Place of examination
3. Chest X-ray Interpretation by the Radiologist (general findings)						
a) Skeletal and/or soft tissue abnormalities?	No	Yes >	Comment on Abnormalities (if preferred, attach a separate written report)			
b) Abnormal great vessel or heart shadows?	No	Yes >				
c) Abnormal hilar shadow and/or lymphatic glands?	No	Yes >				
d) Abnormal hemidiaphragms?	No	Yes >				
e) Abnormal lung fields?	No	Yes >				
f) Any evidence of tubercular lesions?	No	Yes >				
g) Evidence of ANY fibrosis/fibrocalcification involving the upper lobes or superior segments of the lower lobes?	No	Yes >				
h) Any other abnormalities?	No	Yes >				

**4. Record of Special Findings Noted on the Applicant's Chest X-ray Film(s).
Please review the list below and check all appropriate boxes**

MINOR FINDINGS

- 1.1 Single fibrous streak / band / scar
- 1.2 Bony islets
- 2.1 Apical pleural **capping** with a **smooth inferior border (<1 cm. thick** at all points)
- 2.2 Unilateral or bilateral costophrenic angle **blunting (below** the horizontal)
- 2.3 **Calcified nodule(s) in the hilum / mediastinum** with no pulmonary granulomata

MINOR FINDINGS (OCCASIONALLY ASSOCIATED WITH TB INFECTION)

- 3.1 **Solitary Granuloma** (< 1 cm. and of any lobe) with an **unremarkable hilum**
- 3.2 **Solitary Granuloma** (< 1 cm. and of any lobe) with **calcified / enlarged hilar lymph nodes**
- 3.3 Single / Multiple **calcified pulmonary nodules / micronodules with distinct borders**
- 3.4 **Calcified pleural** lesions
- 3.5 Costophrenic Angle **blunting** (either side **above the horizontal**)

FINDINGS SOMETIMES SEEN IN ACTIVE TB OR OTHER CONDITIONS

- 4.0 **Notable** apical pleural **capping** (rough or ragged inferior border and / or ≥ 1 cm. thick at any point)
- 4.1 **Apical fibronodular / fibrocalcific** lesions or apical **calcifications**
- 4.2 Multiple / single **pulmonary nodules / micronodules (non-calcified or poorly defined)**
- 4.3 Isolated **hilar or mediastinal mass / lymphadenopathy** (non-calcified)
- 4.4 **Single / multiple pulmonary nodules / masses ≥ 1 cm.**
- 4.5 Non-calcified **pleural fibrosis** and / or **effusion**
- 4.6 Interstitial fibrosis / parenchymal lung disease / acute pulmonary disease
- 4.7 **ANY cavitating lesion OR "Fluffy" or "Soft" lesions** felt likely to represent **active TB**

NONE OF THE ABOVE ARE PRESENT

5. Certification by the radiologist

DECLARATION: This is a true and correct record of my findings. **IF THE X-RAY LIKELY REPRESENTS ACTIVE TB, THE REFERRING PHYSICIAN WILL BE NOTIFIED DIRECTLY.**

Full name, writing address and telephone number (please print or stamp)

Signature	Date	Day	Month	Year	Location