Fillable Form

Citizenship and Immigration Canada / Citoyenneté et Immigration Canada

PROTECTED WHEN COMPLETED - B

FOR OFFICIAL USE ONLY
CASE PROCESSING CENTRE - VEGREVILLE
IMS Serial Number:
FOSS Client ID:

Medical Report: Section A - EDE /EFE

SPOUSE OR COMMON-LAW PARTNER IN CANADA CLASS

SECTION 1 - You must complete this section. Print clearly, in block letters.

Client Identification & Summary

Surname: (provide alias in brackets)	Forename/First Names	
Sex / Date of Birth (Day, Month, Year) / Country of Birth	Intended Canadian Destination	PHOTO
Mailing Address (If further medical information is required)	Relation to Sponsor: ☐ Spouse or Common-Law Partner ☐ Dependent Child	
Contact Address/Person within Canada (name, full address and telephone number)		

PHOTO
Required for all applicants. Must be taken within six months of the medical examination.

SECTION 2 - To be completed by a Designated Medical Practitioner

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 outpatient treatment. Immediate 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. 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 very unlikely over the next 5-10 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 hospitalization likely in the near future.

☐ **C. Findings that may require more extensive investigation or care. Applicants where:**

(1) HOME/INSTITUTIONAL SUPERVISION & CARE IS NEEDED.
(2) MAJOR HOSPITALIZATION (especially for procedures involving any joint replacements, transplantation, cardiac surgery, subspecialist care, repeated hospitalization) is required.
(3) SPECIALIZED HOSPITAL FACILITIES such as DIALYSIS units or CANCER outpatient clinics is needed.
(4) There is the need for use of intermittent/continuing SOCIAL SERVICES, or specialized educational/vocational training.
(5) DETERIORATION appears quite 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).

EXAMPLES: dementia; mental retardation; developmental delay requiring special educational/training, renal insufficiency; diabetic nephropathy; psychiatric disorders causing clinically significant distress or impairment in social, occupational, or other important areas of functioning; symptomatic heart disease of any cause; dialysis; follow-up for neoplastic disorders; functional impairment due to strokes, etc.; symptomatic peripheral vascular disease; Parkinsonism; multiple sclerosis; renal conditions with the potential of deterioration; genetic/inherited disorders likely to create a functional deficit.

☐ **D. Other conditions/disorders** difficult to categorize or where there is a lack of medical information.

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