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IMPORTANT NOTE TO CLAIMANT

In order to avoid any delays in the assessment of your claim, please have your physician complete the appropriate Initial Attending Physician's Statement form:

- General	**Form no. 12018E01**
- Musculo-skeletal	**Form no. 12019E01**
- Psychiatric/psychological	**Form no. 12020E01**
- Cardiac	**Form no. 12021E01**
- Cancer	**Form no. 12022E01**

We have sent you all five of the above-mentioned Initial Attending Physician's Statement forms, each of which is specific to a particular illness. Please give all five forms to your physician so they can fill out the appropriate one.

It is important that your physician fully complete the form that best corresponds to your medical condition to ensure your claim is processed promptly.

Short Term Disability: Return the complete form to Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, as soon as possible.

Long Term Disability: Return the complete form to Desjardins Insurance no later than six weeks prior to the start of your long-term disability period.

Online: desjardinslifeinsurance.com/send

Desjardins Insurance
PO Box 1203 STN A
Toronto ON M5W 1G6

Fax: 416-926-0697 or 1-844-409-6571

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Desjardins Insurance
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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 YYYY MM DD

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: _____

1.2 Secondary: _____

1.3 Subjective symptoms (including severity, frequency, duration): _____

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: YYYY MM DD

2.2 Date patient's condition first prevented them from working: YYYY MM DD

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: _____

2.8 Current height: Current weight: Weight loss/gain to date:

3. Treatment dates

3.1 Date of first visit for current condition: YYYY MM DD

3.2 Date of latest visit: YYYY MM DD

3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

3.4 Date of in-patient admission: YYYY MM DD

3.5 Date of discharge: YYYY MM DD

3.6 Date of out-patient treatment: YYYY MM DD

3.7 Name of hospital: _____

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): _____

4.2 Surgeries (including dates): _____

4.3 Other (including frequency): _____

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

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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		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.3	Walk on uneven surfaces ☐ Yes ☐ No		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.4	Sit ☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.5	Drive ☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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: Bend: Squat: Kneel: Climb: Reach (above shoulders): Reach (below shoulder):

7. Psychiatric illness (if applicable)

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: _____
8.2 Expected date patient will return to their own occupation: _____ YYYY MM DD
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: _____

9. Rehabilitation

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

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?

_____

_____

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT) | **11.2** Specialty | License no.

11.3 Address - No., street, suite | City | Province | Postal code

11.4 Telephone no.: ( ) - Fax no.: ( ) -

Signature of physician: **Date:**

Submit online:
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Complete and save the form on your computer first.
Keep original forms for your records.

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416-926-0697
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INITIAL ATTENDING PHYSICIAN'S STATEMENT MUSCULO-SKELETAL 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 YYYY MM DD

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

1.1 Primary: _____

_____

1.2 Secondary: _____

_____

1.3 Date symptoms first appeared: YYYY MM DD

1.4 Date patient's condition first prevented them from working: YYYY MM DD

1.5 Date of first visit for treatment or consultation: YYYY MM DD

1.6 Has patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Unknown If yes, state when and describe:

_____

1.7 Is condition a result of an injury due to an accident? ☐ Yes ☐ No If yes, please describe:

_____

1.8 Current height: _____ Current weight: _____ Weight loss/gain to date: _____

1.9 Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
If yes, have Worker's Compensation/CNESST forms been completed? ☐ Yes ☐ No

1.10 Date of latest visit: YYYY MM DD

1.11 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

1.12 Date of hospital inpatient admission: YYYY MM DD

1.13 Date of discharge: YYYY MM DD

1.14 Date of hospital outpatient admission: YYYY MM DD

1.15 Name of hospital: _____

1.16 Other treating physicians: _____

1.17 Pending referrals to specialists: _____

2. Studies

Please outline all objective studies performed/scheduled (X-rays, laboratory data, CT scans, etc.) and attach copies of each report.

Date	Procedure	Results
YYYY MM DD		
YYYY MM DD		
YYYY MM DD		
YYYY MM DD		

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3. Symptoms and signs

Please indicate the nature and severity of the patient's symptoms and signs.

	Please specify location(s) and physical findings	Severe	Moderate	Mild	Absent
Pain		☐	☐	☐	☐
Deformity		☐	☐	☐	☐
Muscle spasm		☐	☐	☐	☐
Muscle atrophy		☐	☐	☐	☐
Loss of tendon reflexes		☐	☐	☐	☐
Sensory change		☐	☐	☐	☐
Motor deficit		☐	☐	☐	☐
Straight leg raising limitation		☐	☐	☐	☐
Range of motion limitation		☐	☐	☐	☐
Other (specify)		☐	☐	☐	☐

If arthritic condition: ☐ In remission ☐ Continuously active ☐ Stable ☐ Seasonally active ☐ Intermittently active ☐ Progressive

If fracture: ☐ Closed ☐ Depressed ☐ Open ☐ Compressed ☐ Comminuted

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): _____

4.2 Physiotherapy (type, frequency, dates): _____

4.3 Surgery date (past): YYYY MM DD Surgery date (future): YYYY MM DD

4.4 Other treatment: _____

4.5 Is patient compliant with prescribed measures? ☐ Yes ☐ No If no, please explain: _____

5. 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
5.1	Stand ☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.2	Walk ☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.3	Walk on uneven surfaces ☐ Yes ☐ No		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.4	Sit ☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.5	Drive ☐ No restriction		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.6	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+
5.7	☐ No restriction ☐ Repetitively: how much?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally: how much?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5.8 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: Bend: Squat: Kneel: Climb: Reach (above shoulders): Reach (below shoulders):

6. Prognosis and return to work plans

6.1 Prognosis for recovery: _____

6.2 Expected date patient will return to their own occupation: YYYY MM DD

6.3 If unknown, please indicate the next follow up date: YYYY MM DD

6.4 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: _____

6.5 Have return to work time lines been discussed with the patient? ☐ Yes ☐ No

6.6 Please elaborate on time frames and patient's response: _____

7. Progress

7.1 Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

7.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

8. Assessment and treatment are complicated by: (please select and explain in the space provided below)

8.1 ☐ Significant emotional or behavioural disorder such as depression, anxiety, etc.

8.2 ☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.

8.3 ☐ Work related issues (please describe if known): _____

8.4 ☐ Substance abuse: _____

8.5 ☐ Other (please describe): _____

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? ☐ Yes ☐ No

9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☐ No

If yes to either of the above, please specify: _____

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?

_____

_____

_____

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT) | **11.2** Specialty | License no.

11.3 Address - No., street, suite | City | Province | Postal code

11.4 Telephone no.: ( ) - | Fax no.: ( ) -

Signature of physician: | **Date:**

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Keep original forms for your records.

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416-926-0697
Keep original forms for your records.

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INITIAL ATTENDING PHYSICIAN'S STATEMENT PSYCHIATRIC/PSYCHOLOGICAL 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 YYYY MM DD

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 psychiatric/counsellor consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (please use DSM-IV criteria)

Supporting data
Please describe the symptoms (severity and frequency), that support each axis of your diagnosis.

1.1 Axis I: _____ _____

_____ _____

_____ _____

1.2 Axis II: _____ _____

1.3 Axis III: _____ _____

1.4 Axis IV: _____ _____

1.5 Axis V - Current GAF score:

2. History

2.1 When did symptoms start and/or worsen? YYYY MM DD

2.2 Date patient's condition first prevented them from working? YYYY MM DD

2.3 Date of first visit for treatment or consultation: YYYY MM DD

2.4 Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown If yes, state when and describe:

_____

_____

2.5 Were work problems a factor in the development of your patient's disorder? ☐ Yes ☐ No If yes, please describe:

_____

_____

2.6 Has a claim been filed with the Workers compensation Board? ☐ Yes ☐ No

2.7 Date of latest visit: YYYY MM DD

2.8 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____

2.9 Are patient's symptoms due to drug or alcohol abuse? ☐ Yes ☐ No

2.10 If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility: _____

2.11 Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state when: YYYY MM DD

3. Treatment for psychiatric/psychological illness

3.1 Is patient seeing or being referred to a psychiatrist? ☐ Yes ☐ No If yes, name of psychiatrist: _____

3.2 If pending, is there an appointment date? ☐ Yes ☐ No If yes, date : YYYY MM DD

3.3 Is patient seeing or being referred to a therapist? ☐ Yes ☐ No If yes, name of therapist: _____

3.4 Date of hospital inpatient admission: YYYY MM DD Date of discharge: YYYY MM DD

Name of hospital:

4. Precipitating and complicating factors

Please describe all factors that may have contributed to the onset of the clinical problem(s) or may complicate their resolution.

☐ Workplace issues ☐ Social/Family issues ☐ Physical/Mental condition ☐ Financial/Legal problems
☐ Coping skills ☐ Alcohol/Drug abuse ☐ Personality/Motivation ☐ Other issues

Comments: _____

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5. Current treatment

5.1 Therapy method: _____

5.2 Therapy goal: _____

5.3 Frequency and length of therapy/counselling sessions: _____

5.4 Number of therapy/counselling sessions to date: _____

5.5 Treatment compliance: _____

5.6 Treatment response to date: _____

5.7 Prognosis and time frame of illness: _____

Medications: Medication name				
Date started	YYYY MM DD	YYYY MM DD	YYYY MM DD	YYYY MM DD
Initial dosage				
Initial response				
Date of last dosage change	YYYY MM DD	YYYY MM DD	YYYY MM DD	YYYY MM DD
Current dosage				
Response				
Side effects				
Compliance				
Date medication discontinued	YYYY MM DD	YYYY MM DD	YYYY MM DD	YYYY MM DD

6. Future treatment plans

What changes in your treatment plan are underway or are being considered?

_____

_____

7. Return to work plans

7.1 Prognosis for recovery: _____

7.2 Expected date patient will return to their own occupation: YYYY MM DD

7.3 If unknown, please indicate the next follow up date: YYYY MM DD

7.4 If your patient is unable to return to their regular occupation, please specifywhen and under what circumstances they could return to work (eg. modified duties, gradual return to work.): _____

_____

7.5 Have return to work time lines been discussed with the patient? ☐ Yes ☐ No

7.6 Please elaborate on time frames and patient's response: _____

_____

7.7 Is your patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No If yes, please specify: _____

_____

7.8 When and under what circumstances could patient return to modified duties or a gradual return to work? _____

8. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition, treatment requirements, and motivation to return to work? _____

_____

_____

9. Identification of physician

9.1 Last name and first name (PLEASE PRINT) | **9.2** Specialty | License no.

9.3 Address - No., street, suite | City | Province | Postal code

9.4 Telephone no.: ( ) - | Fax no.: ( ) -

Signature of physician: **Date:**

Submit online:
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INITIAL ATTENDING PHYSICIAN'S STATEMENT CARDIAC 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 YYYY MM DD

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: _____

_____

1.2 Secondary: _____

_____

1.3 Date symptoms first appeared: YYYY MM DD

1.4 Date patient's condition first prevented them from working: YYYY MM DD

1.5.1 Date of first visit: YYYY MM DD 1.5.2 Date of latest visit: YYYY MM DD

1.6 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

1.7.1 Date of in-patient admission: YYYY MM DD 1.7.2 Date of discharge: YYYY MM DD

1.8 Date of out-patient treatment: YYYY MM DD

1.9 Name of hospital: _____

1.10 Subjective symptoms (including severity/frequency/duration):

2. Findings

2.1 ☐ Chest pain of cardiac origin: ☐ Syncope ☐ Fatigue ☐ Dyspnea due to vascular congestion or hypoxia ☐ Psychophysiologic
☐ Other (please specify): _____

2.2 BP readings over the last 6 months (including dates): _____ YYYY MM DD

_____ YYYY MM DD _____ YYYY MM DD

_____ YYYY MM DD _____ YYYY MM DD

2.3 Current height: _____ Current weight: _____ Weight loss/gain to date: _____

2.4 Current status: ☐ Stable ☐ Improving ☐ Regressing

3. Laboratory tests (completed/scheduled) - Please include copies of relevant test results.

a) EKG: YYYY MM DD
b) Echocardiogram: YYYY MM DD
c) Stress thallium test: YYYY MM DD
d) Pulmonary function test: YYYY MM DD
e) Blood test: YYYY MM DD
f) X-rays: YYYY MM DD
g) Angiogram: YYYY MM DD

4. Treatment

4.1 Medications (dose, frequency, date prescribed): _____ YYYY MM DD

4.2 Other (please describe): _____

4.3.1 Surgery date (past): YYYY MM DD 4.3.2 Surgery date (future): YYYY MM DD

4.4 Other treating physicians: _____

4.5 Is patient compliant with prescribed treatment? ☐ Yes ☐ No If no, please explain: _____

4.6 Has your patient been enrolled in a cardiac rehabilitation program? ☐ Yes ☐ No If yes, provide details:

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5. Restrictions and limitations

5.1 Functional capacity: (Canadian Cardio-Vascular Society (CCS))

☐ Level 1 (no limitation) ☐ Level 2 (mild impairment) ☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

5.2 Functional capacity:

Lifting/Carrying	☐ 1-10 (0.5 - 4.5 kg) ☐ 11-20 (5.0 - 9.1 kg) ☐ 21-50 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Pushing/Pulling	☐ 1-10 (0.5 - 4.5 kg) ☐ 11-20 (5.0 - 9.1 kg) ☐ 21-50 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Standing: _____ hours Walking: _____ blocks Driver's license revoked: ☐ Yes ☐ No		Frequency: _____ Duration: _____

5.3 What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation? _____

5.4 How does this affect the patient's ability to perform activities of daily living? _____

6. Return to work plans

6.1 Prognosis for medical recovery: _____

6.2 Expected date patient will return to their own occupation: YYYY MM DD

6.3 If unknown, please indicate the next follow up date: YYYY MM DD

6.4 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:

7. Assessment and treatment are complicated by: please select and explain in the space provided below.

7.1 ☐ Significant emotional or behavioural disorder such as depression, anxiety, etc.

7.2 ☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

7.3 ☐ Work-related issues (please describe if known): _____

7.4 ☐ Substance abuse

7.5 ☐ Other (please describe):

8. Progress

8.1 Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

8.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): ☐ Yes ☐ No

If yes, please specify: _____

9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☐ No If yes, please specify: _____

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?

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT) | **11.2** Specialty | License no.

11.3 Address - No., street, suite | City | Province | Postal code

11.4 Telephone no.: ( ) - Fax no.: ( ) -

Signature of physician: **Date:**

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Keep original forms for your records.

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INITIAL ATTENDING PHYSICIAN'S STATEMENT CANCER 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 YYYY MM DD

PART 2 - Attending physician's statement

It can be 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 any complications) - Please attach a copy of all consultation, operative and pathology reports.

1.1 Date of cancer diagnosis: YYYY MM DD
1.2 Site of the tumour:
1.3 Type of tumour:
1.4 Histology and staging:

2. History

2.1 Date symptoms first appeared: YYYY MM DD
2.2 Has this patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown
If yes, please specify diagnosis and dates of treatment:
2.3 Describe current symptoms:
2.4 First visit for these symptoms: YYYY MM DD
2.5 Current height: Current weight: Weight loss/gain to date:
2.6 In your opinion, when did the patient's condition first prevent them from working? YYYY MM DD

3. Treatment

3.1 Date of first visit: YYYY MM DD
3.2 Date of latest visit: YYYY MM DD
3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify):
3.4 Treatment - Include information on all treatments to date and future treatment plan, inclusive of:
a) Surgery:
b) Radiation:
c) Hormones:
d) Chemotherapy:

4. Hospitalization (if applicable for this illness or injury)

4.1 Date of in-patient admission: YYYY MM DD
4.2 Date of discharge: YYYY MM DD
4.3 Date of out-patient treatment: YYYY MM DD
4.4 Name of hospital: YYYY MM DD

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5. Therapies

5.1 Describe the therapies to date: ☐ N/A ☐ Partial ☐ Complete

5.2 Describe all co-morbid conditions: _____

5.3 Describe any post therapy sequelae: _____

5.4 Please provide the patient's prognosis for improvement and/or recovery: _____

5.5 Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

6. Patient's current physical abilities

6.1 Please indicate your patient's current physical abilities:

☐ Sedentary duties: Mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

☐ Light duties: Frequent handling of loads of up to 5 kg, sometimes up to 11 kg; may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

☐ Medium duties: Frequent handling of loads up to 11 kg, sometimes up to 23 kg.
Frequent lifting, carrying, pushing and pulling may also be required.

☐ Heavy duties: Frequent handling of loads up to 23 kg, sometimes up to 45 kg.

6.2 In your opinion, what is the earliest date your patient will be able to return to work? YYYY MM DD

6.3 If the previous job could be modified, when could rehabilitation employment commence? YYYY MM DD

7. Comments

7.1 Please provide the names of other physicians who have been/will be involved in assessing the medical problems **and copies of any available consultation reports:** _____

7.2 We would appreciate any additional comments that would help us to better understand your patient and their condition:

8. Identification of physician

8.1 Last name and first name (PLEASE PRINT)			**8.2** Specialty	License no.
8.3 Address - No., street, suite	City	Province	Postal code	
8.4 Telephone no.: ( ) -	Fax no.:	( ) -		
Signature of physician:			**Date:**	