



**Disability claims department**

<b>Montréal</b> P.O. Box 4002 STN B Montréal, Québec H3B 4M2	<b>Toronto</b> P.O. Box 4105 STN A Toronto, Ontario M5W 2P4	<b>Calgary</b> P.O. Box 1315 STN M Calgary, Alberta T2P 2L2	<b>Fax:</b> 1-866-645-4180 <b>Tel:</b> 604-664-8010 1-800-663-1784
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*Please keep the original documents faxed to Standard Life.*

**Attending Physician’s Statement (Physical conditions)**

In order for Standard Life or its agents to properly assess your patient’s claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible. Please note that any costs incurred in the completion of this form are the responsibility of the patient.

**Section A – Information about the patient**

Surname	Given name(s)	Policy no. <b>32548</b>
Date of birth (YYYY/MM/DD)	Height	Weight

**Section B – Diagnosis**

What is the primary diagnosis?

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When did the symptoms first appear or date accident occurred? (YYYY/MM/DD)

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What was the date of the patient’s first visit for his/her current condition? (YYYY/MM/DD)

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What was the date of the patient’s first visit during the present period of absence from work? (YYYY/MM/DD)

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If the patient has a cardiac condition, what is his/her current functional capacity based on the American Heart Association classifications:

Class 1 (No Limitation)       Class 2 (Slight Limitation)       Class 3 (Marked Limitation)       Class 4 (Severe Limitation)

What is the patient’s blood pressure? (YYYY/MM/DD)

Current \_\_\_\_\_ Previous \_\_\_\_\_

If your patient has a back/spinal condition, have an X-ray, MRI, or any other tests been performed?     Yes     No

If Yes, please attach a copy of the results of the X-rays, MRIs, or any other tests which may have been performed.

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work?     Yes     No

If Yes, please elaborate.

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Please provide a complete list of the patient’s symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

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What are the patient’s current limitations (things that he/she cannot do)? Please be specific.

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What are the patient’s current restrictions (things that he/she should not do)? Please be specific.

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Is your patient competent to manage his/her own financial affairs?     Yes     No

Please indicate the date the patient stopped working based on your recommendation. (YYYY/MM/DD)

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If a potential return to work date has been discussed, please provide the date. (YYYY/MM/DD)

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**Attending Physician's Statement (Physical conditions) (continued)**

Has the patient ever had the same or similar condition?  Yes  No  
 If Yes, please provide dates and describe.

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Is the patient's condition due to injury or sickness arising out of his/her employment?  Yes  NO  
 If Yes, please elaborate.

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If the patient was/is pregnant, please indicate the date or expected date of confinement. (YYYY/MM/DD)

**Section C – Treatment**

Frequency of patient visits:  
 Weekly  Bi-weekly  Monthly  Other

Please detail the patient's past and present treatment (e.g. date and type of surgery) as well as response to treatment.

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Has the patient been hospitalized?  Yes  No  
 If Yes, please provide the name of the hospital(s) and the dates of confinement.

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Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)

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If this patient was referred to you, please provide the name of the referring physician.

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If you have referred the patient to a specialist(s), please provide the name(s) of the specialist(s) and area of specialty.

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Signature (YYYY/MM/DD)

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Name (please print) Specialty

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Address (no., street)

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Telephone no. Fax no.



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**Attending Physician’s Statement (Psychological conditions)**

In order for Standard Life or its agents to properly assess your patient’s claim for Disability Benefits, it is important that you answer the following questions in as much detail as possible.

Please note that any costs incurred in the completion of this form are the responsibility of the patient.

**Section A – Information about the patient**

Surname	Given name(s)	Policy no. <b>32548</b>
Date of birth (YYYY/MM/DD)	Height	Weight

**Section B – Diagnosis**

Please indicate the diagnosis using DSM – IV Multi axial evaluation nomenclature and code numbers.

I

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II

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III

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IV

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V

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Is there a secondary diagnosis or additional complication which might affect the duration of absence from work?  Yes  No If Yes, please elaborate.

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Please provide a complete list of your patient’s symptoms (*including severity and frequency*), identifying which of the symptoms listed you have objectively observed.

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When did symptoms first appear? (YYYY/MM/DD)

Please describe the patient’s initial reason for seeking treatment. Was there a precipitating event? (YYYY/MM/DD)

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What was the date of the patient’s first visit for his/her current condition? (YYYY/MM/DD)

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What was the date of the patient’s first visit during the present period of absence from work? (YYYY/MM/DD)

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Is your patient’s condition caused directly or indirectly by his/her employment?  Yes  No If Yes, please elaborate.

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What are the patient’s current limitations (*things that he/she cannot do*)? Please be specific.

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What are the patient’s current restrictions (*things that he/she should not do*)? Please be specific.

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Is your patient competent to manage his/her own financial affairs?  Yes  No

Please indicate the date the patient stopped working based on your recommendation. (YYYY/MM/DD)

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If a potential return to work date has been discussed, please provide the date. (YYYY/MM/DD)

Attending Physician's Statement (Psychological conditions) (continued)

**Section C – Treatment**

Frequency of patient visits:  
 Weekly     Bi-weekly     Monthly     Other

Please detail the patient's past and present treatment (including psychotherapy), response to treatment, and compliance.

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Has the patient been hospitalized?  Yes  No  
 If Yes, please provide the name of the hospital(s) and the dates of confinement.

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Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed (YYYY/MM/DD)

**Section D – Functional capacities evaluation**

Please provide your opinion as to the extent of the patient's impairment in performing the following on a sustained basis:

**None:** No impairment in this area  
**Mild:** Suspected impairment of slight importance which does not affect functional ability.  
**Moderate:** Impairment affects but does not preclude ability to function.  
**Moderately Severe:** Impairment significantly affects ability to function.  
**Severe:** Extreme impairment of ability to function.

	None	Mild	Moderate	Moderately severe	Severe
1. Ability to relate to friends and family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ability to attend to personal care (bathing, cooking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ability to carry out household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ability to relate to co-workers and supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Perform work where contact with others will be minimal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Understand, carry out, and remember instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Perform tasks involving minimal intellectual effort or repetitive tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Perform varied tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ability to follow a regular work schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Make independent judgements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Supervise or manage others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature \_\_\_\_\_ (YYYY/MM/DD)

Name (please print) \_\_\_\_\_ Specialty \_\_\_\_\_

Address (no., street) \_\_\_\_\_

Telephone no. \_\_\_\_\_ Fax no. \_\_\_\_\_