

Attending Physician's Statement - Short Term Disability Claim

Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
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Address (Street, City, Province, Postal Code) _____

Employer's Name	Plan Contract #	Member Certificate #
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Height	Weight	Date of Birth (dd/mm/yyyy) _____
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Last Date Worked (dd/mm/yyyy) _____	Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy) _____
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I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed. I understand that I am responsible for any fees related to the completion of this form.

Plan Member/Employee Signature

Date of Consent (dd/mm/yyyy)

Questions To Be Completed By the Physician (or Nurse Practitioner Where Applicable)



- If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete **Page 1 only** and sign the end of the form.
- For absences expected to be greater than 4 weeks, please complete **Pages 1 and 2 in full**.

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: _____

Secondary and/or Complications: _____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): _____ Vaginal C-Section

Occupational Illness/injury Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto accident Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, date of event: (dd/mm/yyyy) _____	If yes, date of event: (dd/mm/yyyy) _____

Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____	First date of work absence due to condition: (dd/mm/yyyy) _____
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Hospitalization Is/was patient hospitalized or had day surgery

Date of admittance (dd/mm/yyyy) _____	Date of discharge (dd/mm/yyyy) _____	Institution Name _____
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If surgery was performed please provide date and description of surgery

Date (dd/mm/yyyy) _____ Description: _____

Treatment (drug, dosage, physiotherapy, other): _____

Prognosis Please provide the prognosis for recovery: _____

Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this same or similar condition in the past? Yes No

If yes, date: (dd/mm/yyyy) _____ Treatment Provider: _____

Please describe the patient's symptoms including history, severity and frequency: _____

Frequency of Visits: Weekly Monthly Other _____



Please attach copies of all relevant:

- test results/investigations (If test results are not attached, we will interpret this as tests were not performed)
- consultation reports

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty _____ Date of Visit _____

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations.

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Is the patient following the recommended treatment program? Yes No

Do you have concerns about the patient's ability to manage his/her own affairs? Yes No

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ area code)	Fax # (+ area code)	
Signature	Date Signed (dd/mm/yyyy)	