The patient is responsible for any fees related to the completion of this form.

Attending Physician's Statement - Long Term Disability Claim

Section 1 — Plan Member/Employee Information and Consent
TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name	Plan Contract #	Member Certificate #	Date of Birth (dd/mm/yyyy)

Date Last Worked
(dd/mm/yyyy) _____

Date Returned to Work or Expected Return to Work Date
(dd/mm/yyyy) _____

Please list your present medications:

Name of Medication	Dosage (mg)	How Often?
1.		
2.		
3.		
4.		
5.		

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

Left ☐ Right ☐

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. **Medical and health information excludes genetic test results.**

_____ _____
Plan Member/Employee Signature Date of Consent (dd/mm/yyyy)

Section 2 — Attending Physician's Statement
TO BE COMPLETED BY THE DOCTOR

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify)_____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: _____

Secondary: _____

Complications, if relevant: _____

_____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy):

Is this condition due to: Occupational Illness/injury Yes ☐ No ☐ If yes, date of event: (dd/mm/yyyy) _____	Auto accident Yes ☐ No ☐ If yes, date of event: (dd/mm/yyyy) _____
Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐ If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____	
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) _____	First date of work absence due to condition: (dd/mm/yyyy) _____

Treatment

Treatment types include but are not limited to: **special programs**, **therapies**, **medications** (if not noted by patient in **Section 1)**

Response should indicate whether the response to treatment is **complete, partial, too soon to tell,** or **none**.

Treatment Type	Treatment Name	Dosage/ Frequency	Previous History	Previous Provider	Response	Halt Treatment
			Yes ☐ No ☐			Yes ☐ No ☐
			Yes ☐ No ☐			Yes ☐ No ☐
			Yes ☐ No ☐			Yes ☐ No ☐
			Yes ☐ No ☐			Yes ☐ No ☐

Date of last visit: (dd/mm/yyyy) _____

Changes to Treatment Plan

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: _____

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

Investigations

Please attach copies of all relevant:

- **Test results/investigations/test requisitions if results are not yet available. If test results are not attached, we will interpret this as tests were not required.**
  Do not provide genetic test results.
- **Consultation reports or referral requests if consultation reports are not yet available.**

Are tests/investigations pending? Yes ☐ No ☐

Clinical Findings and Observations

- Please outline **Symptoms** as reported by the patient, e.g., pain, anxiety, fatigue, nausea, etc.
- **Frequency and History** should identify the numeric number of days, weeks, months or years in which the symptom has been present.
- **Severity** must identify one of the following: mild, moderate or severe.
- **Status** should indicate whether the patient has: improved, experienced no change, or retrogressed.

Symptom	Frequency	History	Severity	Status

Restrictions and Limitations

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

Cognitive:

Physical:

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy) _____ Type of licence: _____

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

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐ Please elaborate:

Prognosis

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

Return-to-Work

Leave duration: Month(s) TBD, based on prognosis ☐

What return-to-work goals have been discussed with the patient? Yes ☐ No ☐

If Yes, please elaborate:

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.

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