

1 Family name: _____ **2** Given name: _____
3 Contract no.: _____ **4** Social insurance number: _____
Group or Contract no. Certificat no. **5** Date of birth: _____
Y Y Y Y M M D D

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____
 1.2 Secondary: _____
 1.3 Complications: _____
 1.4 For the illnesses or associated symptoms diagnosed, has the patient previously:
 a) received medical treatments b) consulted another physician c) taken drugs d) been hospitalized e) undergone examinations
 Specify the periods: _____
 1.5 Is the disability related to: an accident an illness an occupational accident an automobile accident
 Date of the event: Y Y Y Y M M D D
 a pregnancy No Yes
 a preventive withdrawal from work No Yes Scheduled date of delivery: Y Y Y Y M M D D
 1.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.
 At the beginning of disability Y Y Y Y M M D D Currently _____

2. Treatment

2.1 Drugs - name- dosage _____
 2.2 Has the patient undergone or will undergo:
 a) examinations or tests No Yes Specify: _____
 b) surgery No Yes day surgery Type _____ Date: Y Y Y Y M M D D
 surgical procedure: _____
 c) other treatments? No Yes Specify: _____
 d) hospitalization: from _____ to _____ Name of hospital: _____
 e) a short stay under observation (number of hours): _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D
 3.2 Dates of other consultations: _____ Follow-up frequency: _____
 3.3 Referral to another physician: No Yes Name of physician: _____
 Specialty: _____
 3.4 Approximate duration of disability: No. of days _____ No. of weeks _____ unspecified or date of return to work Y Y Y Y M M D D
 3.5 How long before the patient will be able to return to work? No. of days _____ No. of weeks _____
 part-time full-time gradual return Specify: _____

4. Questions specific to the contract

4.1 In the last five years, has the patient consulted or been treated by a physician or other practitioner, or taken any prescribed drugs for one or any of the following illnesses: cancer or tumor, diabetes, high blood pressure, Crohn's disease, drug addiction or alcoholism, nervous or mental disorders, pulmonary disorder, kidney or genital disorders, cerebral or neurological disorder, musculoskeletal disorders, AIDS related illnesses, or the presence of antibodies to the HIV virus?
 No Yes **If yes, please provide us with the following information:**

Illnesses:	Dates:	Results:	Dates hospitalized:	When has the patient been informed of his condition:

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: _____
 5.2 License number: _____ Fax: _____
 General practitioner Specialist Specify: _____
 Signature: _____ Date: Y Y Y Y M M D D

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Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____
 1.2 Secondary: _____
 1.3 Current symptoms: _____
 1.4 Degree of severity of all symptoms: Mild Moderate Severe with psychotic elements
 1.5 Does the interruption of work result from problems related to:
 marital/family life loss of employment or layoff professional problems
 personal or interpersonal problems alcohol or drug abuse and/or gambling problems
 other problems, specify: _____
 1.6 For the illnesses or associated symptoms diagnosed, has the patient previously:
 a) received medical treatments b) consulted another physician c) taken drugs d) been hospitalized e) undergone examinations
 Specify the dates of previous episodes: _____

2. Treatment

2.1 Drugs - name- dosage: _____
 2.2 Is the patient consulting a psychiatrist? No Yes a social worker? No Yes
 a psychologist? No Yes another health care provider? No Yes
 If yes, name of the caregiver: _____
 2.3 Hospitalization: from _____ to _____ Name of hospital: _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D
 3.2 Dates of other consultations: _____
 3.3 Follow-up frequency: _____
 3.4 Will the patient be referred to a psychiatrist? No Yes Name of physician: _____
 3.5 Approximate duration of disability: No. of days _____ No. of weeks _____ unspecified or date of return to work Y Y Y Y M M D D
 3.6 How long before the patient will be able to return to work? No. of days _____ No. of weeks _____
 part-time full-time gradual return Specify: _____

4. Questions specific to the contract

4.1 In the last five years, has the patient consulted or been treated by a physician or other practitioner, or taken any prescribed drugs for one or any of the following illnesses: cancer or tumor, diabetes, high blood pressure, Crohn's disease, drug addiction or alcoholism, nervous or mental disorders, pulmonary disorder, kidney or genital disorders, cerebral or neurological disorder, musculoskeletal disorders, AIDS related illnesses, or the presence of antibodies to the HIV virus?
 No Yes If yes, please provide us with the following information:

Illnesses:	Dates:	Results:	Dates hospitalized:	When has the patient been informed of his condition:

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: _____
 5.2 License number: _____ Fax: _____
 General practitioner Specialist Specify: _____
 Signature: _____ Date: Y Y Y Y M M D D