142, HÉRIOT, P.O. BOX 696 DRUMMONDVILLE (QUEBEC) J2B 6W9
TEL.: 1 877 567-0988 FAX: (819) 474-1990

Physical illnesses

Note: For psychological illnesses, complete the form on the reverse

Additional report

The insured must complete this section

❶ Family name: ______ ❷ Given name: ______

❸ Contract no.: ______ (Group or Contract no.) ______ (Certificat no.)

❹ Social insurance number: ______

❺ 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 Objective elements of the physical examination and investigation (**attach copy** of recent results, X-rays, ECG, or other tests or examinations)

______

______

Weight: ______ lb ☐ kg ☐ Height: ______ ft/in ☐ ______ m/cm ☐ Most recent blood pressure: ______

1.4 Degree of the symptom's severity (M=mild, Md=moderate, S=severe)

	M	Md	S		M	Md	S
______	☐	☐	☐	______	☐	☐	☐
______	☐	☐	☐	______	☐	☐	☐

2. Treatment

2.1 Drugs - name- dosage ______

2.2 Additional treatments (specify the type and frequency): ______

2.3 Surgery (date, nature and procedure): ______

2.4 Hospitalization: from ______ to ______ Name of hospital: ______

2.5 Consultation with a specialist: No ☐ Yes ☐ → **Attach copy**

3. Medical follow-up and prognosis

3.1 Date of last consultation: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Tests and examinations to come: ______

3.3 Frequency of follow-up: ______

3.4 Referral to a specialist: No ☐ Yes ☐ Name of physician: ______

3.5 Scheduled date of consultation with a specialist: Y Y Y Y M M D D Specialty: ______

3.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability	Currently

3.7 Evolution: progressive ☐ stable ☐ regressive ☐

3.8 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

______

______

3.9 Patient's cooperation in the treatment: excellent ☐ average ☐ poor ☐

3.10 Would the patient benefit from assistance within the scope of a return to work? No ☐ Yes ☐

3.11 Approximate duration of the disability: No. of days ______ No. of weeks ______ Unspecified ☐ or date of return to work Y Y Y Y M M D D

3.12 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

______

______

______

______

______

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

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM.

574-A (11-12)

UL MUTUAL
142, HÉRIOT, P.O. BOX 696 DRUMMONDVILLE (QUEBEC) J2B 6W9
TEL.: 1 877 567-0988 FAX: (819) 474-1990

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Psychological illnesses

Note: For physical illnesses, complete the form on the reverse

Additional report

The insured must complete this section

❶ Family name: ____________
❷ Given name: ____________
❸ Contract no.: ____________ | ____________
Group or Contract no. Certificat no.
❹ Social insurance number: ____________
❺ 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 Please describe the signs and symptoms and indicate the frequency and their individual degree of severity (M=mild, Md=moderate, S=severe)

Signs	M	Md	S	Symptoms	M	Md	S
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

2. Treatment

2.1 Drugs - name- dosage ____________

2.2 **Is the patient consulting a:**

	No	Yes	Since when
psychiatrist	☐	☐	
psychologist	☐	☐	
social worker	☐	☐	
other caregiver	☐	☐	

Is the patient treated:

	No	Yes	Specify:
in a treatment centre	☐	☐	
in a CLSC	☐	☐	
in a day therapy	☐	☐	
in group therapy	☐	☐	
in individual therapy	☐	☐	

AXE II) Associated personality disorders? No ☐ Yes ☐ Specify: ____________
Associated drug addiction, alcoholism or gambling problems? No ☐ Yes ☐ Specify: ____________

AXE III) Associated illness: — diagnosis: ____________
— drugs prescribed: ____________

AXE IV) Associated psychosocial stress factors (in the last 12 months):
☐ 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: ____________

AXE V) General scale of functioning (according to the EGF scale of the DSM IV (0 to 100) 100=perfect condition)
— at the beginning of treatment: ____________ — currently: ____________

3. Follow-up and prognosis

3.1 Date of last consultation: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Follow-up frequency: ____________

3.3 Will the patient be referred to a psychiatrist? No ☐ Yes ☐ Name of physician: ____________

3.4 Patient's cooperation in the treatment: excellent ☐ average ☐ poor ☐

3.5 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

____

____

3.6 Would your patient benefit from assistance within the scope of a return to work? No ☐ Yes ☐

3.7 Do you consider that the patient's condition has improved in an optimal way? No ☐ Yes ☐

3.8 Approximate duration of the disability: No. of days ____ No. of weeks ____ Unspecified ☐ or date of return to work Y Y Y Y M M D D

3.9 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

____

____

____

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

574-A (11-12)

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM.