

## 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)		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)			
Employer's Name		Plan Contract #	Member Certificate #
Height	Weight	Date of Birth (dd/mm/yyyy) _____	
Last Date Worked (dd/mm/yyyy) _____		Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy) _____	
<p>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 may not be assessed. I understand that I am responsible for any fees related to the completion of this form. I agree that a copy or electronic version of this authorization shall be as valid as the original. <b>Medical and health information excludes genetic test results.</b></p>			
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) \_\_\_\_\_

**Hospitalization** Is/was patient hospitalized  or had day surgery  Please provide the following information or attach a copy of the discharge report:

Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
_____	_____	_____

If surgery was performed related to this work absence, 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) - do not provide genetic test results.
- consultation reports • clinical notes

**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.

Name of Attending Physician (please print)	Physician's Specialty	Date Signed (dd/mm/yyyy)
Address:		Telephone # (+ area code)
		Fax # (+ area code)

Signature or Stamp