



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

Initial Disability Insurance Medical Statement

Section 1	Patient Information and Consent TO BE COMPLETED BY THE PATIENT																				
Patient Name (Last, First, Middle Initial)		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)																		
Address (Street, City, Province, Postal Code)																					
Employer's Name (if applicable)		Contract or Policy #	Certificate # (if applicable)																		
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: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">Name of Medication</th> <th style="width: 25%;">Dosage (mg)</th> <th style="width: 25%;">How Often?</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td>_____</td><td>_____</td></tr> <tr><td>2. _____</td><td>_____</td><td>_____</td></tr> <tr><td>3. _____</td><td>_____</td><td>_____</td></tr> <tr><td>4. _____</td><td>_____</td><td>_____</td></tr> <tr><td>5. _____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Name of Medication	Dosage (mg)	How Often?	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	4. _____	_____	_____	5. _____	_____	_____	Please provide your: Height: _____ Weight: _____ Dominant Hand: Left <input type="checkbox"/> Right <input type="checkbox"/>
Name of Medication	Dosage (mg)	How Often?																			
1. _____	_____	_____																			
2. _____	_____	_____																			
3. _____	_____	_____																			
4. _____	_____	_____																			
5. _____	_____	_____																			
<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/insurance policy. 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.</p> <p>I understand that I am responsible for any fees related to the completion of this form. Medical and health information excludes genetic test results.</p>																					
Patient Signature _____		Date of Consent (dd/mm/yyyy) _____																			
Section 2	Medical Statement TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)																				
I am the: Family Physician <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____																					
PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE																					
Diagnosis																					
Primary:																					
Secondary and/or Complications:																					
If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy):		Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/>																			



Is this condition due to:

- Occupational Illness Yes No
- Occupational Injury Yes No
- Motor vehicle accident Yes No
- Other 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

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1**)

Frequency of Visits: Weekly Monthly Other (describe) _____

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

Date of next visit: (dd/mm/yyyy)

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

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

Is the patient following the recommended treatment program? Yes No

Please elaborate: _____

Response to Treatment

Please describe the response to treatment to date: Complete Partial None Too soon to tell

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

Did/will the patient have day surgery? Yes No

Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):

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. _____	_____



- If your patient has returned to work, or if the duration of their disability will be less than 4 weeks, please stop here and sign the end of the form.
- For disabilities expected to be greater than 4 weeks, please complete all pages.

Investigations



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

Are tests/investigations pending? Yes No

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

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes No

Name of Specialist	Specialty	Date (dd/mm/yyyy)
1. _____	_____	_____
2. _____	_____	_____

Clinical Findings and Observations

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

How have the patient's symptoms evolved to date? Improved No Change Retrogressed



Restrictions and Limitations		
<p>Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations:</p> <hr/> <hr/> <hr/>		
<p>Has any license held by the patient been restricted or revoked as a result of this condition? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, as of when? (dd/mm/yyyy) _____ Type of license: _____</p>		
<p>Is the patient capable of managing their own affairs? Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Workplace Issues <input type="checkbox"/> Social/Family Issues <input type="checkbox"/> Financial/Legal Issues <input type="checkbox"/> Personality issues <input type="checkbox"/> Addiction <input type="checkbox"/> Other <input type="checkbox"/></p> <p>Please elaborate:</p> <hr/>		
Prognosis		
<p>Please provide the patient's prognosis for improvement and/or recovery:</p> <hr/> <hr/>		
Return-to-Work		
<p>What return-to-work goals have been discussed with the patient? Please elaborate:</p> <hr/> <hr/>		
<p>Notice to Physician/Medical Provider:</p> <p>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.</p>		
<p>Name of Attending Physician/Medical Provider (please print)</p>	<p>Specialty and license/registration number</p>	<p>Date Signed (dd/mm/yyyy)</p>
<p>Address (Street, City, Province, Postal Code)</p>	<p>Telephone # (+ area code)</p> <p>Fax # (+ area code)</p> <p>Email address</p>	
<p>Signature</p>		