

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

The insured must complete this section

200, rue des Commandeurs, Lévis (Québec) G6V 6R2

1 Family name: _____ **2** Given name: _____
3 Contract no.: _____ Group or policy no. _____ **4** Certificate number: _____
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 _____ Y Y Y Y M M D D
 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 _____ 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 No Yes 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: _____ Y Y Y Y M M D D
 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. Additional information

5. Identification of the physician

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

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

The insured must complete this section

200, rue des Commandeurs, Lévis (Québec) G6V 6R2

1 Family name: _____ **2** Given name: _____
3 Contract no.: _____ **4** Certificate number: _____
Group or policy 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 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 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 consulted: _____

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: _____
Y Y Y Y M M D D

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. Additional information

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: (_____) _____

5.2 License number: _____ Fax: (_____) _____

General practitioner Specialist Specify: _____
Y Y Y Y M M D D

Signature: _____ Date: _____