



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

## Initial Disability Insurance Medical Statement

<b>Section 1</b>	<b>Patient Information and Consent TO BE COMPLETED BY THE PATIENT</b>
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Patient Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
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Address (Street, City, Province, Postal Code)

Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd/mm/yyyy)
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Date Last Worked (dd/mm/yyyy) _____	Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy) _____
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<p>Please list your present medications:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Name of Medication</th> <th style="width:20%;">Dosage (mg)</th> <th style="width:20%;">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. _____	_____	_____	<p>Please provide your:</p> <p>Height: _____</p> <p>Weight: _____</p> <p>Dominant Hand: Left <input type="checkbox"/> Right <input type="checkbox"/></p>
Name of Medication	Dosage (mg)	How Often?																	
1. _____	_____	_____																	
2. _____	_____	_____																	
3. _____	_____	_____																	
4. _____	_____	_____																	
5. _____	_____	_____																	

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.

I understand that I am responsible for any fees related to the completion of this form. **Medical and health information excludes genetic test results.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of Consent (dd/mm/yyyy)

<b>Section 2</b>	<b>Medical Statement TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)</b>
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I am the:    Family Physician     Consulting Specialist     Other  (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     C-Section



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



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