AGA BENEFIT SOLUTIONS
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SUPPLEMENTARY DECLARATION OF ATTENDING PHYSICIAN
Psychological illnesses

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

Section to be filled out by patient

Last name : ______ First name : ______ Date of birth : ______

Contract No. ______ Group/Division No. : ______ Certificate No. : ______

ATTENDING PHYSICIAN'S DECLARATION (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 :**

		Since when?
a psychiatrist	No ☐ Yes ☐	______
a psychologist	No ☐ Yes ☐	______
a social worker	No ☐ Yes ☐	______
an other caregiver	No ☐ Yes ☐	______

Is the patient treated in :

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

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) :

☐ personal or interpersonal problems ☐ loss of employment or layoff ☐ professional problems

☐ marital/family life ☐ alcohol or drug abuse 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: ______ Next consultation: ______

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 : # days ______ # weeks ______ Unspecified ☐ or date of return to work : ______

3.9 How long before the patient will be able to return to work? # days ______ # weeks ______

part-time ☐ full-time ☐ gradual return ☐ Specify : ______

4. QUESTIONS SPECIFIC TO THE CONTRACT

______

______

5. IDENTIFICATION OF THE PHYSICIAN

5.1 Last/First name (block letters) : ______ Telephone : ( )

5.2 License No. : ______ Fax : ( )

General practitioner ☐ Specialist ☐ Specify : ______

5.3 Address : ______

Signature : ______ Date (Y / M / D): ______

NOTE: THE PATIENT MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM