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Lévis (Québec) G6V 0A7
Send original forms and keep copies
for your records.**By fax:**1-844-409-6575 (toll free)
418-835-0194
Keep original forms for your records.**ADDITIONAL REPORT OF ATTENDING PHYSICIAN
FOR PHYSICAL ILLNESSES**

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

1. Identification of the employee - This section must be completed by the employee.

Last name and first name	Policy or group or contract no.	Certificate or identification no.	Date of birth YYYY MM DD
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2. Diagnosis - Complete in block letters and give to the employee.

2.1 Principal: _____

2.2 Secondary: _____

2.3 Objective elements of the physical examination and investigation (attach copy of recent results, X-rays, ECG, or other tests or examinations):

_____Weight: _____ lb kg Height: _____ ft/in m/cm Most recent blood pressure: _____

2.4 Degree of the symptom's severity (M = mild, Md = moderate, S = severe)

	M	Md	S		M	Md	S
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Treatment

3.1 Drugs - name - dosage: _____

3.2 Additional treatments (specify the type and frequency): _____

3.3 Surgery (date, nature and procedure): _____

3.4 Hospitalization: From _____ YYYY MM DD To _____ YYYY MM DD Name of hospital: _____

3.5 Consultation with a specialist: No Yes - **Attach copy.****4. Follow-up and prognosis**

4.1 Date of last consultation: _____ YYYY MM DD Next consultation: _____ YYYY MM DD

4.2 Tests and examinations to come: _____

4.3 Frequency of follow-up: _____

4.4 Referral to a specialist: No Yes Name of physician: _____

4.5 Scheduled date of consultation with a specialist: _____ YYYY MM DD Specialty: _____

4.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability: _____

Currently: _____

4.7 Evolution: Progressive Stable Regressive4.8 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

_____4.9 Patient's cooperation in the treatment: Excellent Average Poor4.10 Would the patient benefit from assistance within the scope of a return to work? No Yes4.11 Approximate duration of the disability: No. of days: _____ No. of weeks: _____ Unspecified or date of return to work: _____ YYYY MM DD

4.12 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: _____**5. Additional information - Please use a separate sheet if necessary.****6. Identification of the physician**

6.1 Family name, given name: _____ Telephone: (____) _____ Fax: (____) _____

6.2 License number: _____ General practitioner Specialist Specify: _____

Signature: _____

Date: _____

NOTE: THE EMPLOYEE MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM.



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ADDITIONAL REPORT OF ATTENDING PHYSICIAN FOR PSYCHOLOGICAL ILLNESSES

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

1. Identification of the employee - This section must be completed by the employee.

Last name and first name	Policy or group or contract no.	Certificate or identification no.	Date of birth YYYY MM DD
--------------------------	---------------------------------	-----------------------------------	-----------------------------

2. Diagnosis - Complete in block letters and give to the employee.

2.1 Principal: _____

2.2 Secondary: _____

2.3 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
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Treatment

3.1 Drugs - name - dosage: _____

3.2 Is the patient consulting: Since when? Is the patient treated in: Specify:

a psychiatrist	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	a treatment centre	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
a psychologist	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	a CLSC	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
a social worker	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	a day hospital	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
an other caregiver	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	group therapy	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
			individual therapy	<input type="checkbox"/> No <input type="checkbox"/> 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) Global assessment of functioning (according to the GAF scale of the DSM IV (0 to 100) 100 = perfect condition)
- at the beginning of treatment: _____ - currently: _____

4. Follow-up and prognosis

4.1 Date of last consultation: _____ YYYY MM DD Next consultation: _____ YYYY MM DD

4.2 Follow-up frequency: _____

4.3 Will the patient be referred to a psychiatrist? No Yes Name of physician: _____

4.4 Patient's cooperation in the treatment: Excellent Average Poor

4.5 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

4.6 Would your patient benefit from assistance within the scope of a return to work? No Yes

4.7 Do you consider that the patient's condition has improved in an optimal way? No Yes

4.8 Approximate duration of the disability: No. of days: _____ No. of weeks: _____ Unspecified or date of return to work: _____ YYYY MM DD

4.9 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: _____

5. Additional information - Please use a separate sheet if necessary.

6. Identification of the physician

6.1 Family name, given name: _____ Telephone: (____) _____ Fax: (____) _____

6.2 License number: _____ General practitioner Specialist Specify: _____

Signature: _____ Date: _____

NOTE: THE EMPLOYEE MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.