Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardinslifeinsurance.com/planmember
1-800-263-1810

HOME NURSING CARE

REQUEST FOR ADDITIONAL INFORMATION

- Please complete **entire** form. If information is missing from the form it will be returned to the member.
- Incomplete forms cannot be processed.
- Any costs associated with the completion of this form are the responsability of the member.

SECTION A. PATIENT IDENTIFICATION – To be completed by the member.

Member's last name and first name	Group no.	Certificate no.
Patient's last name and first name	Date of birth YYYY MM DD	Telephone no.

Address - No., street, apartment | City | Province | Postal code

If the form was completed by the member's legal representative

PLEASE PRINT YOUR NAME: _____ Telephone no.: _____

SECTION B. PATIENT INFORMATION – To be completed by the physician.

1. Please provide a brief summary of the patient's disability, including an approximate date of when the symptoms first appeared:

2. Please indicate your opinion regarding the prognosis:

3. To the best of your knowledge, how long has the patient suffered from this condition: _____ years (YYYY) _____ months (MM DD)

4. Was surgery performed? ☐ Yes ☐ No If so, please indicate the date of surgery: _____
   Specify the nature and the results of the surgery: _____

5. Indicate the level of care required for this patient: ☐ R.N. ☐ R.N.A. ☐ Other: _____

6. Provide a detailed description of the duties that are being or were performed: _____

7. Could someone with lesser qualifications administer or have administered this care? ☐ Yes ☐ No
   If so, please explain: _____

8. Indicate where these services are being or were performed: ☐ Home ☐ Hospital ☐ Other: _____

9. Indicate the duration or expected duration of care: From _____ (YYYY MM DD) To _____ (YYYY MM DD)

10. Specify the number of hours per day: ☐ 4 ☐ 6 ☐ 8 ☐ 16 ☐ 24

11. What type of medication has been prescribed? _____

12. How is or was the medication being administered? _____

13. Please provide any additional comments: _____

SECTION C. PHYSICIAN INFORMATION – Please print.

Physician's last name and first name	Telephone no.	Fax no.

Address - No., street, suite | City | Province | Postal code

Signature of physician: **Date:**

Please send to: Desjardins Insurance, C. P. 3950, Lévis, Québec G6V 8C6

PRINT NEW REQUEST