Attending Physician Statement

(Please take full package to your physician)

Desjardins
Insurance
Life • Health • Retirement

GROUP INSURANCE - DISABILITY CLAIMS

IMPORTANT NOTE TO CLAIMANT

In order to avoid any delays in the assessment of your claim, please have your physician complete the appropriate Initial Attending Physician's Statement form:

- General	Form no. 12018E01
- Musculo-skeletal	Form no. 12019E01
- Psychiatric/psychological	Form no. 12020E01
- Cardiac	Form no. 12021E01
- Cancer	Form no. 12022E01

We have sent you all five of the above-mentioned Initial Attending Physician's Statement forms, each of which is specific to a particular illness. Please give all five forms to your physician so they can fill out the appropriate one.

It is important that your physician fully complete the form that best corresponds to your medical condition to ensure your claim is processed promptly.

Short Term Disability: Return the complete form to Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, as soon as possible.

Long Term Disability: Return the complete form to Desjardins Insurance no later than six weeks prior to the start of your long-term disability period.

Online: desjardinslifeinsurance.com/send

Desjardins Insurance
PO Box 1203 STN A
Toronto ON M5W 1G6

Fax: 416-926-0697 or 1-844-409-6571

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Desjardins Insurance
Life · Health · Retirement

INITIAL ATTENDING PHYSICIAN'S STATEMENT PSYCHIATRIC/PSYCHOLOGICAL FORM

- PLEASE PRINT.
- PART 1 to be completed by patient.
- PART 2 to be completed by physician.
- Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)	Policy or group or contract no.	Certificate or identification no.	Date of birth
	641028		YYYY MM DD

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any psychiatric/counsellor consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (please use DSM-IV criteria)

Supporting data
Please describe the symptoms (severity and frequency), that support each axis of your diagnosis.

1.1 Axis I: _____
1.2 Axis II: _____
1.3 Axis III: _____
1.4 Axis IV: DSM V PGO — sadness, preoccupation, decreased interests, wish to trade places, decreased, increased trouble, concentration
1.5 Axis V - Current GAF score:

2. History

2.1 When did symptoms start and/or worsen? 2021 10 30
2.2 Date patient's condition first prevented them from working? 2021 11 02
2.3 Date of first visit for treatment or consultation: 2021 11 02
2.4 Has patient ever had same or similar condition? ☐ Yes ☑ No ☐ Unknown — If yes, state when and describe:
2.5 Were work problems a factor in the development of your patient's disorder? ☐ Yes ☑ No — If yes, please describe:
2.6 Has a claim been filed with the Workers compensation Board? ☐ Yes ☑ No
2.7 Date of latest visit: 2021 11 23
2.8 Frequency of visits: ☐ Weekly ☐ Monthly ☑ Other: every 2-3 weeks
2.9 Are patient's symptoms due to drug or alcohol abuse? ☐ Yes ☑ No
2.10 If yes, is patient enrolled in a substance abuse program? ☐ Yes ☑ No N/A — If yes, state facility:
2.11 Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☑ No — If yes, state when: YYYY MM DD

3. Treatment for psychiatric/psychological illness

3.1 Is patient seeing or being referred to a psychiatrist? ☐ Yes ☑ No — If yes, name of psychiatrist:
3.2 If pending, is there an appointment date? ☐ Yes ☑ No — If yes, date: YYYY MM DD
3.3 Is patient seeing or being referred to a therapist? ☑ Yes ☐ No — If yes, name of therapist: ~~Crisis worker~~ Registered Psychotherapist Shirley Watchhorn Minom'shki-ki
3.4 Date of hospital inpatient admission: YYYY MM DD — Date of discharge: YYYY MM DD
Name of hospital:

4. Precipitating and complicating factors

Please describe all factors that may have contributed to the onset of the clinical problem(s) or may complicate their resolution.

☐ Workplace issues ☑ Social/Family issues ☐ Physical/Mental condition ☐ Financial/Legal problems
☐ Coping skills ☐ Alcohol/Drug abuse ☐ Personality/Motivation ☐ Other issues
Comments: Death of patient's sister in horrific accident 1 year ago.

5. Current treatment

5.1 Therapy method: CBT grief counselling

5.2 Therapy goal: manage grief effectively, return to work

5.3 Frequency and length of therapy/counselling sessions: biweekly or weekly (now weekly due to time off work)

5.4 Number of therapy/counselling sessions to date: weekly - biweekly since July 2021

5.5 Treatment compliance: Compliant

5.6 Treatment response to date: improving, set back at 1 year anniversary of sisters death (Oct 21)

5.7 Prognosis and time frame of illness: good prognosis - timeframe: increased symptoms since Nov 2020

Medications: Medication name				
Date started	YYYY MM DD	YYYY MM DD	YYYY MM DD	YYYY MM DD
Initial dosage	N/A			
Initial response				
Date of last dosage change	YYYY MM DD	YYYY MM DD	YYYY MM DD	YYYY MM DD
Current dosage				
Response				
Side effects				
Compliance				
Date medication discontinued	YYYY MM DD	YYYY MM DD	YYYY MM DD	YYYY MM DD

6. Future treatment plans

What changes in your treatment plan are underway or are being considered?

increased counselling to weekly sessions

7. Return to work plans

7.1 Prognosis for recovery: good prognosis

7.2 Expected date patient will return to their own occupation: 2021 12 14

7.3 If unknown, please indicate the next follow up date: YYYY MM DD

7.4 If your patient is unable to return to their regular occupation, please specifywhen and under what circumstances they could return to work (eg.: modified duties, gradual return to work.):

7.5 Have return to work time lines been discussed with the patient? ☑ Yes ☐ No

7.6 Please elaborate on time frames and patient's response: Patient agreeable to try & return to work in 2 weeks she will be reassessed dec 14/21

7.7 Is your patient a suitable candidate for vocational rehabilitation? ☐ Yes ☑ No If yes, please specify:

7.8 When and under what circumstances could patient return to modified duties or a gradual return to work? If she does not improve in 2 weeks at follow up apt

8. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition, treatment requirements, and motivation to return to work? Patient is very motivated to return to work. her sister passed away 1 year ago in a horrific car accident. She is now responsible for helping care for her sister's daughter with her mother. she is also responsible for caring for her elderly father.

9. Identification of physician

9.1 Last name and first name (PLEASE PRINT): Barker-Pi, Theresa

9.2 Specialty: Nurse Practitioner

License no.: 1355090

9.3 Address - No., street, suite: 2 Water Lane PO Box 10

City: Kirkland Lake

Province: ON

Postal code: P2N 3M6

9.4 Telephone no.: (705) 567 2224

Fax no.: (705) 567 3838

Signature of physician: Theresa B-P

Date: 11/23/21

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0597
Keep original forms for your records.

Desjardins Insurance
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INITIAL ATTENDING PHYSICIAN'S STATEMENT GENERAL FORM

- PLEASE PRINT.
- PART 1 to be completed by patient.
- PART 2 to be completed by physician.
- Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)	Policy or group or contract no.	Certificate or identification no.	Date of birth
	641028		YYYY MM DD

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including complications) - If psychiatric, give DSM-IV code.

1.1 Primary: Situational Stress related to grief; Bereavement; reviewed DSM-5 criteria & differentiated bereavement from MDD. DSM IV code V 62.82

1.2 Secondary: ~~Anxiety - situational~~ error TBP, IN-EC decreased mood

1.3 Subjective symptoms (including severity, frequency, duration): Difficulty concentrating, decreased attention span, decreased mood, tearfullness, difficulty sleeping

1.4 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings): N/A

1.5 Degree of severity of all symptoms: ☐ Mild ☑ Moderate ☐ Severe ☐ With psychotic elements

2. History

2.1 Date symptoms first appeared or accident happened: 2020 11 01

2.2 Date patient's condition first prevented them from working: 2021 11 02

2.3 Has this patient ever had same or similar condition? ☐ Yes ☑ No ☐ Unknown

If yes, please specify diagnosis and dates of treatment:

2.4 Is condition due to injury or sickness arising out of patient's employments? ☐ Yes ☑ No ☐ Unknown

2.5 Have Worker's Compensation/CSST forms been completed? ☐ Yes ☑ No ☐ Unknown

2.6 If patient is pregnant, give E.D.C.: YYYY MM DD

2.7 Names and specialties of other treating physicians: Grief counsellor

2.8 Current height: Current weight: Weight loss/gain to date:

3. Treatment dates

3.1 Date of first visit for current condition: 2021 11 02

3.2 Date of latest visit: 2021 11 23

3.3 Frequency of visits: ☐ Weekly ☑ Monthly ☑ Other (specify): as needed

3.4 Date of in-patient admission: YYYY MM DD

3.5 Date of discharge: YYYY MM DD

3.6 Date of out-patient treatment: YYYY MM DD

3.7 Name of hospital:

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): N/A

4.2 Surgeries (including dates): N/A

4.3 Other (including frequency): Grief counselling - weekly, biweekly

4.4 Is patient following recommended treatment program? ☑ Yes ☐ No (please elaborate):

5. Progress

5.1 Has patient: ☐ Recovered ☑ Improved ☐ Not improved ☐ Retrogressed
5.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

6. Restrictions and limitations

			HOURS AT ONE TIME					TOTAL HOURS DURING THE DAY				
			<1	<1-2	<2-4	4-6	6-8	<1	<1-2	<2-4	4-6	6-8
6.1	Stand	☑ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.2	Walk	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.3	Walk on uneven surfaces	☐ Yes ☑ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.4	Sit	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.5	Drive	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.6	This patient can lift/carry a maximum of: No restriction	kgs	0	5	9	14	18	23	27	32	36	41+
		lbs	0	10	20	30	40	50	60	70	80	90+
6.7	☑ No restriction	☐ Repetitively: how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐ Occasionally: how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6.8 Please indicate in the space provided if this patient is able to perform the following actions: Frequently (F), Occasionally (O), or Not at all (N):
Drive: F Bend: F Squat: F Kneel: F Climb: F Reach (above shoulders): F Reach (below shoulder): F

7. Psychiatric illness (if applicable)

7.1 History: No previous mental health history
7.2 Precipitating chronological events: horrific, sudden death of patient's sister Nov 1/2020
7.3 Work issue related to this illness: Ø 1st time ever
7.4 Pre-morbid personality: stable, calm personality
7.5 Changes in ADL habits: Ø change in ADL history
7.6 Familial risk factors: Patient primary caregiver of aging parents & assisting 1 niece's care
7.7 Progress with treatment plan: Good progress & grief counselling; required additional 2 weeks off of work
7.8 Are patient's symptoms related to drug or alcohol abuse? ☐ Yes ☑ No
If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No If yes, state facility:
7.9 Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☑ No If yes, state when: yyyy mm dd

8. Return to work plans

8.1 Prognosis for improvement or recovery: Expected to return to work after ~~Nov 23~~ Dec 14/21; good prognosis
8.2 Expected date patient will return to their own occupation: 2021 Nov 23
8.3 If unknown, please indicate the next follow up date: yyyy mm dd / N/A
8.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work:
8.5 Have return to work time lines been discussed with the patient? ☑ Yes ☐ No
8.6 Please elaborate on time frames and patient's response: Patient is happy to return to work at agreed date, Dec 14/21
A follow up is booked Dec 14/21

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): ☐ Yes ☑ No
If yes, please specify:
9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☑ No If yes, please specify:

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?
Patient's sister passed away 1 year ago in a horrific accident, she is now responsible for helping 1 her sister's daughter & aging parents. She experienced increased stress and grief at the 1 year anniversary of her sister's death.

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT): Barber-Pin, Theresa
11.2 Specialty: Nurse Practitioner
License no.: 13550908
11.3 Address - No., street, suite: 2 Water Lane Po Box 10
City: Kirkland Lake
Province: ON
Postal code: P2N 3M6
11.4 Telephone no.: (705) 567 2224
Fax no.: (705) 567 3838
Signature of physician: Theresa Barber-Pin
Date: 11/23/21