

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	<input checked="" type="checkbox"/> No restriction	<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"/>
6.2 Walk	<input checked="" type="checkbox"/> No restriction	<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"/>
6.3 Walk on uneven surfaces	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<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"/>
6.4 Sit	<input checked="" type="checkbox"/> No restriction	<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"/>
6.5 Drive	<input checked="" type="checkbox"/> No restriction	<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"/>
6.6 This patient can lift/carry a maximum of:	<u>N/A</u> kgs	0	5	9	14	18	23	27	32	36	41+
	lbs	0	10	20	30	40	50	60	70	80	90+
6.7	<input checked="" type="checkbox"/> No restriction <input type="checkbox"/> Repetitively: how much? <input type="checkbox"/> Occasionally: how much?	<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"/>
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:	Bend:	Squat:	Kneel:	Climb:	Reach (above shoulders):	Reach (below shoulder):					

7. Psychiatric illness (if applicable)

- 7.1 History: The patient son has been admitted to hospital in critical condition
 7.2 Precipitating chronological events: N/A
 7.3 Work issue related to this illness: N/A
 7.4 Pre-morbid personality: N/A
 7.5 Changes in ADL habits: N/A
 7.6 Familial risk factors: As above
 7.7 Progress with treatment plan: Treatment plan in hospital will be changing
 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: _____

8. Return to work plans

- 8.1 Prognosis for improvement or recovery: Unknown - will depend on status of sons health.
 8.2 Expected date patient will return to their own occupation: Unknown
 8.3 If unknown, please indicate the next follow up date: Planned April 22, 2024
 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: Unknown
 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: Based on absences with son

9. Rehabilitation - N/A

- 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?

11. Identification of physician

- 11.1 Last name and first name (PLEASE PRINT) Myers, Tracy 11.2 Specialty Nurse Practitioner License no. CG875632
 11.3 Address - No., street, suite 200 Anenki Place, Fort William City Fort William Province ON Postal code L7S 1L6
 11.4 Telephone no.: (607) 626-5200 Fax no.: (607) 623-0536
 Signature of physician: [Signature] Date: 03/22/24



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**INITIAL ATTENDING PHYSICIAN'S STATEMENT
 MUSCULO-SKELETAL FORM**

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

N/A

PART 1 - Identification of patient

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

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

- 1.1 Primary: _____
- 1.2 Secondary: _____
- 1.3 Date symptoms first appeared: _____
- 1.4 Date patient's condition first prevented them from working: _____
- 1.5 Date of first visit for treatment or consultation: _____
- 1.6 Has patient ever had the same or similar condition? Yes No Unknown If yes, state when and describe: _____
- 1.7 Is condition a result of an injury due to an accident? Yes No If yes, please describe: _____
- 1.8 Current height: _____ Current weight: _____ Weight loss/gain to date: _____
- 1.9 Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown
 If yes, have Worker's Compensation/CNESST forms been completed? Yes No
- 1.10 Date of latest visit: _____
- 1.11 Frequency of visits: Weekly Monthly Other (specify): _____
- 1.12 Date of hospital inpatient admission: _____
- 1.13 Date of discharge: _____
- 1.14 Date of hospital outpatient admission: _____
- 1.15 Name of hospital: _____
- 1.16 Other treating physicians: _____
- 1.17 Pending referrals to specialists: _____

2. Studies

Please outline all objective studies performed/scheduled (X-rays, laboratory data, CT scans, etc.) and attach copies of each report.

Date	Procedure	Results

3. Symptoms and signs

Please indicate the nature and severity of the patient's symptoms and signs.

	Please specify location(s) and physical findings	Severe	Moderate	Mild	Absent
Pain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deformity		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasm		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle atrophy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of tendon reflexes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory change		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor deficit		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Straight leg raising limitation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Range of motion limitation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If arthritic condition: <input type="checkbox"/> In remission <input type="checkbox"/> Continuously active <input type="checkbox"/> Stable <input type="checkbox"/> Seasonally active <input type="checkbox"/> Intermittently active <input type="checkbox"/> Progressive					
If fracture: <input type="checkbox"/> Closed <input type="checkbox"/> Depressed <input type="checkbox"/> Open <input type="checkbox"/> Compressed <input type="checkbox"/> Comminuted					

4. Nature of treatment

- 4.1 Medications (dose, frequency, date prescribed): _____
- 4.2 Physiotherapy (type, frequency, dates): _____
- 4.3 Surgery date (past): _____ Surgery date (future): _____
- 4.4 Other treatment: _____
- 4.5 Is patient compliant with prescribed measures? Yes No If no, please explain: _____

5. 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
5.1 Stand	<input type="checkbox"/> No restriction	<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"/>
5.2 Walk	<input type="checkbox"/> No restriction	<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"/>
5.3 Walk on uneven surfaces	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/>
5.4 Sit	<input type="checkbox"/> No restriction	<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"/>
5.5 Drive	<input type="checkbox"/> No restriction	<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"/>
5.6 This patient can lift/carry a maximum of:	kgs	0	5	9	14	18	23	27	32	36	41+
	lbs	0	10	20	30	40	50	60	70	80	90+
5.7	<input type="checkbox"/> No restriction <input type="checkbox"/> Repetitively: how much? <input type="checkbox"/> Occasionally: how much?	<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"/>
5.8	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:	Bend:	Squat:	Kneel:	Climb:	Reach (above shoulders):	Reach (below shoulders):				

6. Prognosis and return to work plans

- 6.1 Prognosis for recovery: _____
- 6.2 Expected date patient will return to their own occupation: _____
- 6.3 If unknown, please indicate the next follow up date: _____
- 6.4 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: _____
- 6.5 Have return to work time lines been discussed with the patient? Yes No
- 6.6 Please elaborate on time frames and patient's response: _____

7. Progress

- 7.1 Has patient: Recovered Improved Not improved Retrogressed
- 7.2 Current status: Ambulatory House confined Bed confined Hospital confined



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INITIAL ATTENDING PHYSICIAN'S STATEMENT PSYCHIATRIC/PSYCHOLOGICAL FORM

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

N/A

PART 1 - Identification of patient

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

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/counselor 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: _____
 1.5 Axis V - Current GAF score: _____

2. History

- 2.1 When did symptoms start and/or worsen? _____
 2.2 Date patient's condition first prevented them from working? _____
 2.3 Date of first visit for treatment or consultation: _____
 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: _____
 2.8 Frequency of visits: Weekly Monthly Other: _____
 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 If yes, state facility: _____
 2.11 Has your patient ever been enrolled in a substance abuse program? Yes No If yes, state when: _____

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: _____
 3.3 Is patient seeing or being referred to a therapist? Yes No If yes, name of therapist: _____
 3.4 Date of hospital inpatient admission: _____ Date of discharge: _____
 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: _____

8. Assessment and treatment are complicated by: (please select and explain in the space provided below)

- 8.1 Significant emotional or behavioural disorder such as depression, anxiety, etc.
- 8.2 Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.
- 8.3 Work related issues (please describe if known): _____
- 8.4 Substance abuse: _____
- 8.5 Other (please describe): _____

9. Rehabilitation

- 9.1 Is patient a suitable candidate for medical rehabilitation services? Yes No
 - 9.2 Is patient a suitable candidate for vocation rehabilitation? Yes No
- If yes to either of the above, 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?

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT)		11.2 Specialty		License no.	
11.3 Address - No., street, suite		City		Province	Postal code
11.4 Telephone no.: ()		Fax no.: ()			
Signature of physician:				Date:	



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INITIAL ATTENDING PHYSICIAN'S STATEMENT CARDIAC FORM

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

N/A

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

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: _____

1.2 Secondary: _____

1.3 Date symptoms first appeared: _____

1.4 Date patient's condition first prevented them from working: _____

1.5.1 Date of first visit: _____ 1.5.2 Date of latest visit: _____

1.6 Frequency of visits: Weekly Monthly Other (specify): _____

1.7.1 Date of in-patient admission: _____ 1.7.2 Date of discharge: _____

1.8 Date of out-patient treatment: _____

1.9 Name of hospital: _____

1.10 Subjective symptoms (including severity/frequency/duration): _____

2. Findings

2.1 Chest pain of cardiac origin: Syncope Fatigue Dyspnea due to vascular congestion or hypoxia Psychophysiologic
 Other (please specify): _____

2.2 BP readings over the last 6 months (including dates): _____

2.3 Current height: _____ Current weight: _____ Weight loss/gain to date: _____

2.4 Current status: Stable Improving Regressing

3. Laboratory tests (completed/scheduled) - Please include copies of relevant test results.

- a) EKG: _____ e) Blood test: _____
 b) Echocardiogram: _____ f) X-rays: _____
 c) Stress thallium test: _____ g) Angiogram: _____
 d) Pulmonary function test: _____

4. Treatment

4.1 Medications (dose, frequency, date prescribed): _____

4.2 Other (please describe): _____

4.3.1 Surgery date (past): _____ 4.3.2 Surgery date (future): _____

4.4 Other treating physicians: _____

4.5 Is patient compliant with prescribed treatment? Yes No If no, please explain: _____

4.6 Has your patient been enrolled in a cardiac rehabilitation program? Yes No If yes, provide details: _____

5. Current treatment

- 5.1 Therapy method: _____
- 5.2 Therapy goal: _____
- 5.3 Frequency and length of therapy/counselling sessions: _____
- 5.4 Number of therapy/counselling sessions to date: _____
- 5.5 Treatment compliance: _____
- 5.6 Treatment response to date: _____
- 5.7 Prognosis and time frame of illness: _____

Medications:	Medication name			
	Date started			
	Initial dosage			
	Initial response			
	Date of last dosage change			
	Current dosage			
	Response			
	Side effects			
	Compliance			
	Date medication discontinued			

6. Future treatment plans

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

7. Return to work plans

- 7.1 Prognosis for recovery: _____
- 7.2 Expected date patient will return to their own occupation: _____
- 7.3 If unknown, please indicate the next follow up date: _____
- 7.4 If your patient is unable to return to their regular occupation, please specify when 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: _____
- 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? _____

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?

9. Identification of physician

- 9.1 Last name and first name (PLEASE PRINT) _____
- 9.2 Specialty _____ License no. _____
- 9.3 Address - No., street, suite _____ City _____ Province _____ Postal code _____
- 9.4 Telephone no.: () _____ Fax no.: () _____
- Signature of physician: _____ Date: _____



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INITIAL ATTENDING PHYSICIAN'S STATEMENT CANCER FORM

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

N/A

PART 1 - Identification of patient

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

PART 2 - Attending physician's statement

It can be 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 any complications) - Please attach a copy of all consultation, operative and pathology reports.

- 1.1 Date of cancer diagnosis: _____
- 1.2 Site of the tumour: _____
- 1.3 Type of tumour: _____
- 1.4 Histology and staging: _____

2. History

- 2.1 Date symptoms first appeared: _____
- 2.2 Has this patient ever had same or similar condition? Yes No Unknown
If yes, please specify diagnosis and dates of treatment: _____

- 2.3 Describe current symptoms: _____
- 2.4 First visit for these symptoms: _____
- 2.5 Current height: _____ Current weight: _____ Weight loss/gain to date: _____
- 2.6 In your opinion, when did the patient's condition first prevent them from working? _____

3. Treatment

- 3.1 Date of first visit: _____
- 3.2 Date of latest visit: _____
- 3.3 Frequency of visits: Weekly Monthly Other (specify): _____
- 3.4 Treatment - include information on all treatments to date and future treatment plan, inclusive of:
 - a) Surgery: _____
 - b) Radiation: _____
 - c) Hormones: _____
 - d) Chemotherapy: _____

4. Hospitalization (If applicable for this illness or injury)

- 4.1 Date of in-patient admission: _____
- 4.2 Date of discharge: _____
- 4.3 Date of out-patient treatment: _____
- 4.4 Name of hospital: _____

5. Restrictions and limitations

5.1 Functional capacity: (Canadian Cardio-Vascular Society (CCS))

- Level 1 (no limitation) Level 2 (mild impairment) Level 3 (moderate impairment) Level 4 (severe impairment)

5.2 Functional capacity:

Lifting/Carrying	<input type="checkbox"/> 1-10 (0.5 - 4.5 kg) <input type="checkbox"/> 11-20 (5.0 - 9.1 kg) <input type="checkbox"/> 21-50 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Pushing/Pulling	<input type="checkbox"/> 1-10 (0.5 - 4.5 kg) <input type="checkbox"/> 11-20 (5.0 - 9.1 kg) <input type="checkbox"/> 21-50 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Standing: _____ hours		Frequency: _____
Walking: _____ blocks		Duration: _____
Driver's license revoked: <input type="checkbox"/> Yes <input type="checkbox"/> No		

5.3 What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation? _____

5.4 How does this affect the patient's ability to perform activities of daily living? _____

6. Return to work plans

6.1 Prognosis for medical recovery: _____

6.2 Expected date patient will return to their own occupation: _____

6.3 If unknown, please indicate the next follow up date: _____

6.4 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: _____

7. Assessment and treatment are complicated by: please select and explain in the space provided below.

- 7.1 Significant emotional or behavioural disorder such as depression, anxiety, etc.
7.2 Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations
7.3 Work-related issues (please describe if known): _____
7.4 Substance abuse
7.5 Other (please describe): _____

8. Progress

- 8.1 Has patient: Recovered Improved Not improved Retrogressed
8.2 Current status: Ambulatory House confined Bed confined Hospital confined

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?

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT)	11.2 Specialty	License no.	
11.3 Address - No., street, suite	City	Province	Postal code
11.4 Telephone no.: ()	Fax no.: ()		
Signature of physician:	Date:		

5. Therapies

5.1 Describe the therapies to date: N/A Partial Complete

5.2 Describe all co-morbid conditions: _____

5.3 Describe any post therapy sequelae: _____

5.4 Please provide the patient's prognosis for improvement and/or recovery: _____

5.5 Is the condition due to injury or sickness arising out of the patient's employment? Yes No

6. Patient's current physical abilities

6.1 Please indicate your patient's current physical abilities:

- Sedentary duties: Mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.
- Light duties: Frequent handling of loads of up to 5 kg, sometimes up to 11 kg; may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.
- Medium duties: Frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.
- Heavy duties: Frequent handling of loads up to 23 kg, sometimes up to 45 kg.

6.2 In your opinion, what is the earliest date your patient will be able to return to work? _____

6.3 If the previous job could be modified, when could rehabilitation employment commence? _____

7. Comments

7.1 Please provide the names of other physicians who have been/will be involved in assessing the medical problems and copies of any available consultation reports: _____

7.2 We would appreciate any additional comments that would help us to better understand your patient and their condition: _____

8. Identification of physician

8.1 Last name and first name (PLEASE PRINT)		8.2 Specialty		License no.
8.3 Address - No., street, suite		City	Province	Postal code
8.4 Telephone no.: () -		Fax no.: ()		
Signature of physician:				Date: