Status Update - Confirmation of Ongoing Long Term Disability

Section A	Plan Member/Employee Information and Consent To be Completed by the Patient	
Plan Member/Employee Name (Last, First, Middle Initial)	Phone # (+ Area Code)	E-mail address
Address (Street, City, Province, Postal Code)		
Plan Contract #	Plan Member Certificate #	Date of Birth (dd/mm/yyyy)

I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim may not be assessed. I understand that I am responsible for any fees related to the completion of this form. I agree that a copy or electronic version of this authorization shall be as valid as the original. **Medical and health information excludes genetic test results.**

_____ Plan Member/Employee Signature

_____ Date of Consent (dd/mm/yyyy)

Section B — Status Update Since Last Report
To be Completed by the Physician (or Nurse Practitioner where applicable)

I am the: ☐ Attending Physician ☐ Consulting Specialist ☐ Other (please specify) _____

1) Diagnosis

Primary Diagnosis: ☐ Unchanged since last report ☐ Changed since last report - please elaborate:

Secondary Diagnosis: ☐ Not Applicable ☐ Unchanged since last report ☐ Changed since last report - please elaborate:

2) Current Symptoms

Please describe the patient's current symptoms including frequency and severity:

Since the last report, have the patient's symptoms:

☐ Improved ☐ Worsened ☐ Remained the same

3) Complicating Factors

Please indicate if there are any recurrent factors that may be contributing to the clinical problem(s) and may complicate the patient's recovery period, OR ☐ **No new contributing factors since last report**

Complications related to:

☐ Workplace Issues ☐ Social / Family Issues ☐ Financial / Legal Problems
☐ Physical Condition ☐ Alcohol / Drug Abuse ☐ Medication Side Effects
☐ Pain Perception ☐ Coping Skills ☐ Personality / Motivation ☐ Other

Please describe:

_____

_____

_____

Please describe the supports in place, or planned, to assist with these issues:

_____

_____

4) Restrictions and Limitations

Please list the patient's current restrictions and limitations:

_____

_____

_____

_____

Please describe the patient's degree of:	Mild	Moderate	Severe	Not Applicable
Physical impairment	☐	☐	☐	☐
Psychological impairment	☐	☐	☐	☐

Since your last report, has the degree of impairment: ☐ Improved ☐ Worsened ☐ Remained the same

5) Investigations

Date of your last visit with the patient (dd/mm/yyyy) _____ Date of your next scheduled visit (dd/mm/yyyy)_____

Please attach copies of any new and relevant test results, investigations or consultation reports. **If test results are not attached, we will interpret this as no new tests performed since your last report. Do not provide genetic test results.**

Have referrals been made for future tests, investigations or consultations? ☐ Yes ☐ No

If so, referred to:	Type of specialty, investigation or test :	Date of appt: (dd/mm/yyyy)
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Reason for requesting the referral or test:

_____

_____

_____

_____

6) Current Medications (please attach separate list if insufficient space)

☐ **Unchanged since last report**

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)

7) Hospitalization

Has the patient been hospitalized since your last report? ☐ Yes ☐ No

Reason for hospitalization: _____

	Date admitted (dd/mm/yyyy)	Date discharged (dd/mm/yyyy)	Institution Name
1.	_____	_____	_____
2.	_____	_____	_____

Is future hospitalization anticipated? ☐ Yes ☐ No

	If so, date (dd/mm/yyyy)	Description of surgery or nature of hospitalization:
1.	_____	_____
2..	_____	_____

8) Current Treatment Details

Type of Therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)
			Wkly ☐ Mthly ☐ Other ☐	
			Wkly ☐ Mthly ☐ Other ☐	
			Wkly ☐ Mthly ☐ Other ☐	
			Wkly ☐ Mthly ☐ Other ☐	

9) Overall Response to Treatment Program

Please describe the response to treatment to date: ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

Is the patient following the recommended treatment program? ☐ Yes ☐ No

If not, please elaborate: _____

Are there any plans to change or augment the current treatment program? ☐ Yes ☐ No ☐ Too soon to tell

Please elaborate: _____

10) Prognosis and Recovery

At this stage, have return-to-work goals been discussed with the patient? ☐ Yes ☐ No

Please explain the return-to-work plan:

Please provide the patient's prognosis for improvement:

Please provide any other information that will help us understand the patient's current condition, recovery goals and prognosis:

Notice to Health Information Provider:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician (or Nurse Practitioner where applicable)	Specialty
Address: E-mail Address	Telephone # (+ area code) Fax # (+ area code)
Signature or Stamp	Date Signed (dd/mm/yyyy)