Attending Physician's Questionnaire – Mental Health Conditions

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)

Employer's Name	Plan Contract #	Member Certificate #	Date of Birth (dd/mm/yyyy)

Date Last Worked (dd/mm/yyyy) ________________	**Date Returned to Work or Expected Return to Work Date, if known** (dd/mm/yyyy) ____________________	**Please provide your:** Height: ________ Weight: __________

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	Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR

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

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1) Diagnosis

Primary: ____

____

Secondary: ____

____

Is this condition related to: ☐ Occupational Illness/injury ☐ Auto accident If so, date of event: (dd/mm/yyyy) ____________

Details: ____

____

____

Date of first visit to you pertaining to this condition: (dd/mm/yyyy) ______________________	First date of work absence due to this condition: (dd/mm/yyyy) ______________________

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date: (dd/mm/yyyy) ______________________ By whom: ______________________

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) ________________

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2) Patient's Description of Symptoms

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

____
____
____
____
____

3) Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy / Vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration / Focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect/Mood	☐	☐	☐	☐
Insight/Judgement	☐	☐	☐	☐
Self-Criticism	☐	☐	☐	☐

Observations or comments supporting the above:

____
____

4) Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

☐ 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:

____
____
____
____

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5) Investigations

Please attach copies of all relevant:

- test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - **do not provide genetic test results.**
- consultation reports

Are tests / investigations / consultations pending? Yes ☐ No ☐ Date report expected: (dd/mm/yyyy) ______________________

Does the patient have an appointment booked with any specialist(s) in the near future? Yes ☐ No ☐

Name of Specialist	Specialty	Date of Appt: (dd/mm/yyyy)
1.________________	________________	________________
2.________________	________________	________________

Reason for requesting the consultation:

____

____

Has any licence held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐ Don't Know ☐

If yes, as of when? (dd/mm/yyyy) ___________________ Type of licence: ______________________________

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

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

7) Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization anticipated? Yes ☐ No ☐

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

8) Treatment Details - Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

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

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9) Treatment Details - Concurrent Physiological Disorders, if known (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

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

10) Overall Response to Treatment

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 ☐

Please explain: ______________________________

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

If so, please explain: ______________________________

11) Prognosis and Recovery

What return-to-work goals have been discussed with the patient? Please explain:

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 Physician

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 (please print)	Physician's Specialty	Date Signed (dd/mm/yyyy)
Address:		Telephone # (+ area code) Fax # (+ area code)
Signature or Stamp		

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