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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

ADDITIONAL REPORT OF ATTENDING PHYSICIAN FOR PHYSICAL ILLNESSES

Note: For psychological illnesses, complete the form on the reverse.

1. Identification of the employee - This section must be completed by the employee.

Last name and first name	Policy or group or contract no.	Certificate or identification no.	Date of birth
			YYYY MM DD

2. Diagnosis - Complete in block letters and give to the employee.

2.1 Principal: _____

2.2 Secondary: _____

2.3 Objective elements of the physical examination and investigation (attach copy of recent results, X-rays, ECG, or other tests or examinations):

_____

_____

Weight: _____ ☐ lb ☐ kg Height: _____ ☐ ft/in ☐ m/cm Most recent blood pressure: _____

2.4 Degree of the symptom's severity (M = mild, Md = moderate, S = severe)

	M	Md	S		M	Md	S
_____	☐	☐	☐	_____	☐	☐	☐
_____	☐	☐	☐	_____	☐	☐	☐

3. Treatment

3.1 Drugs – name – dosage: _____

_____

3.2 Additional treatments (specify the type and frequency): _____

3.3 Surgery (date, nature and procedure): _____

3.4 Hospitalization: From YYYY MM DD To YYYY MM DD Name of hospital: _____

3.5 Consultation with a specialist: ☐ No ☐ Yes - **Attach copy.**

4. Follow-up and prognosis

4.1 Date of last consultation: YYYY MM DD Next consultation: YYYY MM DD

4.2 Tests and examinations to come: _____

4.3 Frequency of follow-up: _____

4.4 Referral to a specialist: ☐ No ☐ Yes Name of physician: _____

4.5 Scheduled date of consultation with a specialist: YYYY MM DD Specialty: _____

4.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability: _____

Currently: _____

4.7 Evolution: ☐ Progressive ☐ Stable ☐ Regressive

4.8 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

_____

_____

4.9 Patient's cooperation in the treatment: ☐ Excellent ☐ Average ☐ Poor

4.10 Would the patient benefit from assistance within the scope of a return to work? ☐ No ☐ Yes

4.11 Approximate duration of the disability: No. of days: _____ No. of weeks: _____ ☐ Unspecified or date of return to work: YYYY MM DD

4.12 How long before the patient will be able to return to work? No. of days: _____ No. of weeks: _____

☐ Part-time ☐ Full-time ☐ Gradual return Specify:

5. Additional information - Please use a separate sheet if necessary.

6. Identification of the physician

6.1 Family name, given name: _____ Telephone: ( ) _____ Fax: ( ) _____

6.2 License number: _____ ☐ General practitioner ☐ Specialist Specify: _____

Signature: **Date:**

NOTE: THE EMPLOYEE MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM.

PRINT NEW REQUEST

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

ADDITIONAL REPORT OF ATTENDING PHYSICIAN FOR PSYCHOLOGICAL ILLNESSES

Note: For physical illnesses, complete the form on the reverse.

1. Identification of the employee - This section must be completed by the employee.

Last name and first name	Policy or group or contract no.	Certificate or identification no.	Date of birth YYYY MM DD

2. Diagnosis - Complete in block letters and give to the employee.

2.1 Principal: _____

2.2 Secondary: _____

2.3 Please describe the signs and symptoms and indicate the frequency and their individual degree of severity (M = mild, Md = moderate, S = severe)

Signs	M	Md	S	Symptoms	M	Md	S
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

3. Treatment

3.1 Drugs – name – dosage: _____

3.2

Is the patient consulting:			Since when?	Is the patient treated in:			Specify:
a psychiatrist	☐ No	☐ Yes		a treatment centre	☐ No	☐ Yes	
a psychologist	☐ No	☐ Yes		a CLSC	☐ No	☐ Yes	
a social worker	☐ No	☐ Yes		a day hospital	☐ No	☐ Yes	
an other caregiver	☐ No	☐ Yes		group therapy	☐ No	☐ Yes	
				individual therapy	☐ No	☐ Yes	

AXE II) Associated personality disorders: ☐ No ☐ Yes Specify: _____
Associated drug addiction, alcoholism or gambling problems: ☐ No ☐ Yes Specify:

AXE III) Associated illness: – diagnosis: _____
– drugs prescribed:

AXE IV) Associated psychosocial stress factors (in the last 12 months):
☐ Personal or interpersonal problems ☐ Loss of employment or layoff ☐ Professional problems
☐ Marital/family life ☐ Alcohol or drug abuse or gambling problems
☐ Other problems, specify:

AXE V) Global assessment of functioning (according to the GAF scale of the DSM IV (0 to 100) 100 = perfect condition)
– at the beginning of treatment: – currently:

4. Follow-up and prognosis

4.1 Date of last consultation: YYYY MM DD Next consultation: YYYY MM DD

4.2 Follow-up frequency: _____

4.3 Will the patient be referred to a psychiatrist? ☐ No ☐ Yes Name of physician: _____

4.4 Patient's cooperation in the treatment: ☐ Excellent ☐ Average ☐ Poor

4.5 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

4.6 Would your patient benefit from assistance within the scope of a return to work? ☐ No ☐ Yes

4.7 Do you consider that the patient's condition has improved in an optimal way? ☐ No ☐ Yes

4.8 Approximate duration of the disability: No. of days: _____ No. of weeks: _____ ☐ Unspecified or date of return to work: YYYY MM DD

4.9 How long before the patient will be able to return to work? No. of days: _____ No. of weeks: _____
Part-time ☐ Full-time ☐ Gradual return ☐ Specify:

5. Additional information - Please use a separate sheet if necessary.

6. Identification of the physician

6.1 Family name, given name: _____ Telephone: ( ) Fax: ( )

6.2 License number: _____ ☐ General practitioner ☐ Specialist Specify: _____

Signature: **Date:**

NOTE: THE EMPLOYEE MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM.

PRINT NEW REQUEST

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.