Desjardins Insurance
Life • Health • Retirement

Case postale 3800, Lévis (Québec) G6V 0S1 / www.desjardinslifeinsurance.com/send

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Physical Illnesses

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

RESET

Additional report

The insured must complete this section

❶ Family name: _____ ❷ Given name: _____

❸ Contract no.: _____ | _____ (Group or policy no. | Certificate no.)

❹ Date of birth: Y Y Y Y M M D D

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____

1.2 Secondary: _____

1.3 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: _____

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

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

2. Treatment

2.1 Drugs – name – dosage: _____

_____

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

2.3 Surgery (date, nature and procedure): _____

2.4 Hospitalization: from _____ to _____ Name of hospital: _____

2.5 Consultation with a specialist: No ☐ Yes ☐ → **Attach copy**

3. Follow-up and prognosis

3.1 Date of last consultation: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Tests and examinations to come: _____

3.3 Frequency of follow-up: _____

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

3.5 Scheduled date of consultation with a specialist: Y Y Y Y M M D D Specialty: _____

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

At the beginning of disability	Currently
_____	_____
_____	_____

3.7 Evolution: progressive ☐ stable ☐ regressive ☐

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

_____

_____

3.9 Patient's cooperation in the treatment: excellent ☐ average ☐ poor ☐

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

3.11 Approximate duration of the disability: No. of days _____ No. of weeks _____ Unspecified ☐ or date of return to work Y Y Y Y M M D D

3.12 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: _____

4. Questions specific to the contract

_____

_____

_____

_____

_____

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: _____ Area code + number

5.2 License number: _____ Fax: _____ Area code + number

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: Y Y Y Y M M D D

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Psychological Illnesses

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

RESET

Additional report

The insured must complete this section

❶ Family name: _____ ❷ Given name: _____

❸ Contract no.: _____ (Group or policy no.) _____ (Certificate no.)

❹ Date of birth: Y Y Y Y M M D D

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____

1.2 Secondary: _____

1.3 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
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

2. Treatment

2.1 Drugs – name – dosage: _____

2.2

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) General scale of functioning (according to the EGF scale of the DSM IV (0 to 100) 100 = perfect condition)

– at the beginning of treatment _____ – currently _____

3. Follow-up and prognosis

3.1 Date of last consultation: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Follow-up frequency: _____

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

3.4 Patient's cooperation in the treatment: excellent ☐ average ☐ poor ☐

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

_____

_____

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

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

3.8 Approximate duration of the disability: No. of days _____ No. of weeks _____ Unspecified ☐ or date of return to work Y Y Y Y M M D D

3.9 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: _____

4. Questions specific to the contract

_____

_____

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: _____ Area code + number

5.2 License number: _____ Fax: _____ Area code + number

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: Y Y Y Y M M D D

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM