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Desjardins Insurance
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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

INITIAL ATTENDING PHYSICIAN'S STATEMENT 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 Complications: _____

2.4 For the illnesses or associated symptoms diagnosed, has the patient previously:

☐ received medical treatments ☐ consulted another physician ☐ taken drugs ☐ been hospitalized ☐ undergone examinations

Specify the periods: _____

2.5 Is the disability related to: ☐ An accident ☐ An illness ☐ An occupational accident ☐ An automobile accident ☐ A pregnancy ☐ A preventive withdrawal from work

Date of the event: _____ YYYY MM DD

Scheduled date of delivery: _____ YYYY MM DD

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

At the beginning of disability: _____ YYYY MM DD : _____

Currently:

3. Treatment

3.1 Drugs – name – dosage: _____

3.2 Has the patient undergone or will undergo:

a) examinations or tests ☐ No ☐ Yes Specify: _____

b) surgery ☐ No ☐ Yes ☐ Day surgery Type: _____ Date: _____ YYYY MM DD

Surgical procedure: _____

c) other treatments ☐ No ☐ Yes Specify: _____

d) hospitalization: From _____ YYYY MM DD To _____ YYYY MM DD Name of hospital: _____

e) a short stay under observation ☐ No ☐ Yes Number of hours:

4. Follow-up and prognosis

4.1 Date of first consultation for this disability: _____ YYYY MM DD Next consultation: _____ YYYY MM DD

4.2 Dates of other consultations: _____ Follow-up frequency: _____

4.3 Referral to another physician: ☐ No ☐ Yes Name of physician: _____

Specialty: _____

4.4 Approximate duration of disability: No. of days: _____ No. of weeks: _____ ☐ Unspecified or date of return to work: _____

4.5 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.

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

INITIAL ATTENDING PHYSICIAN'S STATEMENT 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 Current symptoms: _____

2.4 Degree of severity of all symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ With psychotic elements

2.5 Does the interruption of work result from problems related to:

☐ Marital/family life ☐ Loss of employment or layoff ☐ Professional problems
☐ Personal or interpersonal problems ☐ Alcohol or drug abuse or gambling problems

☐ Other problems, specify: _____

2.6 For the illnesses or associated symptoms diagnosed, has the patient previously:

☐ received medical treatments ☐ consulted another physician ☐ taken drugs ☐ been hospitalized ☐ undergone examinations

Specify the dates of previous episodes:

3. Treatment

3.1 Drugs – name – dosage: _____

_____

3.2 Is the patient consulting: ☐ a psychiatrist ☐ a psychologist ☐ a social worker ☐ another health care provider

If yes, name of the caregiver consulted: _____

3.3 Hospitalization: From: YYYY MM DD To: YYYY MM DD Name of hospital:

4. Follow-up and prognosis

4.1 Date of first consultation for this disability: YYYY MM DD Next consultation: YYYY MM DD

4.2 Dates of other consultations: _____

4.3 Follow-up frequency: _____

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

4.5 Approximate duration of disability: No. of days: _____ No. of weeks: _____ ☐ Unspecified or date of return to work: _____

4.6 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.

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