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 C. P. 3875 succ. Lévis
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 1-844-409-6575 (toll free)
 418-835-0194
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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
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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:

<input type="checkbox"/> An accident	<input type="checkbox"/> An illness	Date of the event: _____ YYYY MM DD
<input type="checkbox"/> An occupational accident	<input type="checkbox"/> An automobile accident	
<input type="checkbox"/> A pregnancy	<input type="checkbox"/> A preventive withdrawal from work	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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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.