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For physical illnesses, please complete the form specific to that purpose (F.29549-502).

IDENTIFICATION OF THE INSURED

First name _____ Last name _____ Date of birth (YYYY MM DD) _____ Gender: M F

PHYSICIAN'S STATEMENT

In order for us to properly assess the insured's claim, please answer all questions in as much detail as possible.

A. GENERAL INFORMATION

1. Are you the family physician? No Yes

a) If so, how long have you been this person's physician (YYYY MM DD): _____

b) If not, provide the name and contact information of the family physician:

2. To the best of your knowledge, does the patient currently use tobacco or marijuana, or a nicotine replacement product in any form whatsoever? No Yes Don't know

If so:

a) Indicate the type of substance and quantity consumed per day: _____

b) How long has the patient been using this substance on a continuous basis (YYYY MM DD)? _____

c) To the best of your knowledge, has the patient ever stopped using these substances for periods of time (from what date to what date)?

If not:

d) To the best of your knowledge, has the patient ever used tobacco or marijuana, or a nicotine replacement product in any form whatsoever? No Yes Don't know

e) If so, specify the period(s) (from what date to what date) when he/she used these substances:

f) Indicate the type of substance and quantity consumed per day: _____

g) When did the patient stop using this substance (YYYY MM DD): _____

3. To the best of your knowledge, over the last three (3) years, has the patient used any unprescribed narcotics or drugs?
 No Yes Don't know

4. To the best of your knowledge, over the last three (3) years, has the patient received treatment or joined any organization because of his/her alcohol consumption, or has a health professional advised him/her to reduce his/her alcohol consumption?
 No Yes Don't know

B. DIAGNOSIS - Please use the DSM V nomenclature and codes to answer the following questions.

5. AXIS I

Primary diagnosis: _____
Secondary diagnosis: _____

6. AXIS II

Associated personality disorders? No Yes Specify: _____
Associated drug addiction, alcoholism or gambling problems? No Yes Specify: _____

7. AXIS III - Associated illness

Diagnosis: _____
Drugs prescribed: _____

8. AXIS IV - Associated psychological stress factors

Personal or interpersonal problems Marital or family life Professional problems
 Loss of employment or layoff Alcohol or drug abuse, gambling problems
 Other, specify: _____

9. Specify the trigger:

10. What are the current symptoms you have observed in the patient?

11. How severe are the overall symptoms? Mild Moderate Severe With psychotic elements

12. When did the first symptoms appear? _____

13. Examination of current mental state (psychomotor skills, mood, affect, state of mind, cognitive skills):

14. What are the patient's cognitive or mental limitations and their degree of severity?

- a) Concentration: No limitation Mild Moderate Severe
b) Social interaction skills: No limitation Mild Moderate Severe
c) Understanding: No limitation Mild Moderate Severe
d) Reasoning: No limitation Mild Moderate Severe
e) Other: Specify: _____
f) Describe what day-to-day activities are affected by these limitations and how:

15. Indicate the reason for the patient's initial consultation:

16. Are there any complications that could extend the period of disability? No Yes

- a) If so, provide details:

17. Has the patient ever had the same or a similar condition? No Yes Don't know

a) If so, indicate when (YYYY MM DD) and describe the condition in detail and treatment received:

C. TREATMENT

18. Medication, dosage and date prescribed:

a) Gradual increase: _____

b) Potentiation: _____

c) Has there been any change in medication or do you anticipate such a change? No Yes

If yes, specify: _____

19. Is the patient consulting a: psychologist? No Yes Other? No Yes If yes, specify: _____

a) If so, indicate the name and contact information of the professional:

20. Has the patient been hospitalized for this condition? No Yes

Specify:

Date admitted (YYYY MM DD)

Date discharged (YYYY MM DD)

Name of the hospital

Address of the hospital (No., street, city, province, postal code)

21. Is the patient following the recommended treatment plan? No Yes

a) If not, provide details:

D. FOLLOW-UP AND PROGNOSIS

22. Date the patient stopped working because of his/her illness (YYYY MM DD): _____

23. Did the patient consult you on this date? No Yes

a) If not, provide the name and contact information of the physician the patient consulted on the date of his/her work stoppage:

b) When did he/she consult you for the first time (YYYY MM DD)? _____

24. Dates of consultations: _____

a) Frequency of consultations: _____ Next consultation: _____

25. Will the patient be referred to a psychiatrist? No Yes

a) Name of physician: _____

b) Frequency of consultations: _____

26. If you anticipate that the absence from work will exceed the usual period for such a diagnosis, specify the factors that justify your prognosis:

27. Approximate duration of incapacity: _____ or _____ or _____
No. of weeks No. of months Scheduled date of return to work (YYYY MM DD)

