



The patient is responsible for any fees related to the completion of this form.

Initial Disability Insurance Medical Statement

Section 1	Patient Information and Consent TO BE COMPLETED BY THE PATIENT																					
Patient Name (Last, First, Middle Initial)		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)																			
Address (Street, City, Province, Postal Code)																						
Employer's Name (if applicable)		Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd/mm/yyyy)																		
Date Last Worked (dd/mm/yyyy) _____		Date Returned to Work or Expected Return to Work Date (dd/mm/yyyy) _____																				
Please list your present medications:			Please provide your:																			
<table border="1"><thead><tr><th>Name of Medication</th><th>Dosage (mg)</th><th>How Often?</th></tr></thead><tbody><tr><td>1. _____</td><td>_____</td><td>_____</td></tr><tr><td>2. _____</td><td>_____</td><td>_____</td></tr><tr><td>3. _____</td><td>_____</td><td>_____</td></tr><tr><td>4. _____</td><td>_____</td><td>_____</td></tr><tr><td>5. _____</td><td>_____</td><td>_____</td></tr></tbody></table>			Name of Medication	Dosage (mg)	How Often?	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	4. _____	_____	_____	5. _____	_____	_____	Height: _____ Weight: _____ Dominant Hand: Left ☐ Right ☐	
Name of Medication	Dosage (mg)	How Often?																				
1. _____	_____	_____																				
2. _____	_____	_____																				
3. _____	_____	_____																				
4. _____	_____	_____																				
5. _____	_____	_____																				
I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed. I understand that I am responsible for any fees related to the completion of this form. Medical and health information excludes genetic test results. _____ Patient Signature _____ Date of Consent (dd/mm/yyyy)																						
Section 2	Medical Statement TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)																					
I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) _____																						
PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE																						
Diagnosis																						
Primary: _____																						
Secondary and/or Complications: _____																						
If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): _____ Vaginal ☐ C-Section ☐																						



Is this condition due to:

Occupational Illness Yes ☐ No ☐
 Occupational Injury Yes ☐ No ☐
 Motor vehicle accident Yes ☐ No ☐
 Other accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Date of first visit to you pertaining to this condition:
 (dd/mm/yyyy) _____

First date of work absence due to condition:
 (dd/mm/yyyy) _____

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1**)

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (dd/mm/yyyy) _____

Date of next visit: (dd/mm/yyyy) _____

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐ Unknown ☐

If yes, date: (dd/mm/yyyy) _____ Treatment Provider: _____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate: _____

Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: _____

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

Did/will the patient have day surgery? Yes ☐ No ☐

Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):

Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

If surgery was/will be performed, please provide date(s) and description of surgery(s):

Date (dd/mm/yyyy)

Description

1. _____
2. _____



- If your patient has returned to work, or if the duration of their disability will be less than 4 weeks, please stop here and sign the end of the form.
- For disabilities expected to be greater than 4 weeks, please complete all pages.

Investigations



Please attach copies of all relevant:

- test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results
- consultation reports
- clinical notes

Are tests/investigations pending? Yes ☐ No ☐

Date (dd/mm/yyyy)

Description

1. _____
2. _____

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

Name of Specialist

Specialty

Date (dd/mm/yyyy)

1. _____
2. _____

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency: _____

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐



Restrictions and Limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations: _____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐
 If yes, as of when? (dd/mm/yyyy) _____ Type of license: _____

Is the patient capable of managing their own affairs? Yes ☐ No ☐

Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐

Workplace Issues ☐ Social/Family Issues ☐ Financial/Legal Issues ☐ Personality issues ☐ Addiction ☐ Other ☐

Please elaborate: _____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery: _____

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate: _____

Notice to Physician/Medical Provider:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician/Medical Provider (please print)	Specialty and license/registration number	Date Signed (dd/mm/yyyy)
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Address (Street, City, Province, Postal Code)	Telephone # (+ area code) Fax # (+ area code) Email address
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Signature _____