Ellement

ATTENDING PHYSICIANS' STATEMENT

Please print clearly and complete the form in full. Please return to Ellement Consulting Group for processing.
Fax: 204-954-7310 Email: disabilityclaims@ellement.ca Mail: 1345 Taylor Ave, Winnipeg MB, R3M 3Y9

Patient Information		
Patient Last Name:	Patient First Name:	Date of Birth: (dd/mm/yyyy)
Date first seen for this illness/injury:		
Is the disability the result of a work-related illness/injury? YES: ☐ NO: ☐		
Is the absence the result of an accident? YES: ☐ NO: ☐		
If Yes, please describe:		

Physical Diagnosis
Primary Diagnosis:
Secondary Diagnosis and Complications:
Objective medical findings, including a copy of the results of all diagnostic tests:

Psychiatric Diagnosis (DSM 5)			
Primary Diagnosis:			
Secondary Diagnosis and Complications:			
Severity of psychosocial stressors (0-non-existent; 1-mild; 3-moderate; 5-severe)			
Select One: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5			
Factors that may have contributed to the onset of the clinical problems or may complicate the recovery:			
☐ Workplace issues	☐ Personality or Motivation	☐ Financial or Legal problems	☐ Physical or Medical conditions
☐ Coping Skills	☐ Social or Family issues	☐ Alcohol or Drug abuse	
☐ Other issues:			

Symptoms	
When did the symptoms first appear:	From what date did the medical condition prevent the patient from working:
Has the patient ever had the same or similar condition? ☐ YES: provide date (dd/mm/yyyy) ☐ NO	Did you recommend the patient to stop work: ☐ YES: provide date (dd/mm/yyyy) ☐ NO

List all current symptoms your patient is experiencing and the degree of severity (Mild, Moderate, Severe)

Treatment

If your patient has been hospitalized, please confirm admission and discharge date(s):
From: To:

If surgery was or will be performed, please provide the date and description of surgery:

What is the nature of the current treatment plan: (example: therapies, special programs referrals to specialists etc.?)

Has the patient been referred to a specialist or other health care provider? ☐ Yes ☐ No
If Yes, please indicate the name and specialty, if No, why?

Is the patient following the recommended treatment program? ☐ Yes ☐ No
If No, why?

What is the prognosis for recovery:

Return to Work

Has a return-to-work date been established? ☐ Yes ☐ No If Yes, what is the expected return-to-work date (dd/mm/yyyy):

Select one: ☐ Full time ☐ Part time ☐ Gradual

Week 1:	**From:**	**Number of hrs per day:**	
Week 2:	**From:**	**Number of hrs per day:**	
Week 3:	**From:**	**Number of hrs per day:**	
Week 4:	**From:**	**Number of hrs per day:**	
Week 5:	**From:**	**Number of hrs per day:**	
Week 6:	**From:**	**Number of hrs per day:**	

If the patient is unable to return to work in any capacity, when will they be reassessed for a possible return to work (dd/mm/yyyy):

Other		
Are there any other non-medical factors that may impact the patient's expected recovery period and return to work plan:		
Physician information and signature		
Name of physician:	Specialty:	Phone number:
Address:	Fax number:	Email address:
Signature:	Date: (dd/mm/yyyy)	

Privacy Statement: Ellement Consulting Group will collect, use, maintain and disclose only the personal information considered necessary for the administration of the plan. Personal information will be protected pursuant to the relevant legislation. The plan may use and exchange information with the relevant persons and/or organisations, such as Institutions, Government Agencies, Investigating Agencies, the Union, Trustees, Companies affiliated with Ellement Consulting Group, Insurers, Re-Insurers, Auditors, and Regulators in order to manage the plan and entitlement to the benefits of the plan. Questions related to the privacy policy should be directed to our Privacy Officer by mail, or by email at privacy@ellement.ca