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Attending Physician's Statement - Short-Term Disability Claim

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

Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)		
Employer's Name	Group Plan #	Employee/Plan Member Certificate #
Height / Weight	Date of Birth (dd/mm/yyyy) _____	
Last Date Worked (dd/mm/yyyy) _____	**Date Returned to Work or Expected Return to Work Date** (dd/mm/yyyy) _____	

I hereby authorize the release of medical and health information in my file to Wawanesa Life and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. 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.

_____ Plan Member/Employee Signature

_____ Date of Consent (dd/mm/yyyy)

Attending Physician's Statement: TO BE COMPLETED BY THE DOCTOR

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: _____

_____

_____

Secondary and/or Complications: _____

_____

_____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): _____ Vaginal ☐ C-Section ☐

Occupational Illness/injury Yes ☐ No ☐
If yes, date of event: (dd/mm/yyyy) _____

Auto accident Yes ☐ No ☐
If yes, date of event: (dd/mm/yyyy) _____

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

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

Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy) _____ Date of discharge (dd/mm/yyyy) _____ Institution Name _____

If surgery was performed please provide date and description of surgery
Date (dd/mm/yyyy) _____ Description: _____

Treatment (drug, dosage, physiotherapy, other):

_____

_____

Prognosis Please provide the prognosis for recovery (i.e. estimated duration of absence):

_____

_____

Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

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

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

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

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other_____

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, w will interpret this as tests were not performed)**
- **consultation reports and chart notes**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist_____Specialty_____Date of Visit _____

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

Please list any complications and additional conditions impacti g your patient's level of function or the expected recovery period.

Is the patient following the recommended treatment program?	Yes ☐	No ☐
Do you have concerns about the patient's ability to manage their own affairs?	Yes ☐	No ☐

Prognosis Please provide the prognosis for recovery (i.e. estimated duration of absence), if not completed on page 1:

Notice to Physician:

The information in his 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. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ area code)	Fax # (+ area code)	
Signature	Date Signed (dd/mm/yyyy)	

Functional Abilities Form

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Policy/Claim # _____

This form is to be completed by the treating health practitioner. When completed, this form is used to enable an employer to accommodate an ill or injured employee, or if absence is unavoidable, to return to work as soon as they are safely able.

Please note: As this form is shared with the Employer, please do not provide diagnosis, symptoms or treatment information.

1. Date of Examination (dd/mm/yyyy):_____ Area of Injury: _____
2. Is the employee capable of returning to work immediately without restrictions? ☐ Yes ☐ No (if no, complete below)

Estimate abilities unless specified:

Walking: ☐ Full abilities ☐ Up to 100 metres ☐ 100 – 200 metres ☐ Other (specify)	**Standing:** ☐ Full abilities ☐ Up to 15 minutes ☐ 15 – 30 minutes ☐ Other (specify)	**Sitting:** ☐ Full abilities ☐ Up to 30 minutes ☐ 30 minutes to 1 hr. ☐ Other (specify)	**Stair Climbing** ☐ None ☐ 2 – 3 steps only ☐ Short flight ☐ Other (specify)	**Drive a car:** ☐ Yes ☐ No
Lifting floor to waist: ☐ Full abilities ☐ Up to 5 kg ☐ 5 – 10 kg ☐ Other (specify)	**Lifting waist to shoulder:** ☐ < 5 kg ☐ 5 – 9 kg ☐ 10 – 25 kg ☐ Other (specify)	**Lifting/Reaching above shoulder:** ☐ < 5 kg ☐ 5 – 9 kg ☐ 10 – 25 kg ☐ Other (specify)	**Limited ability to:** ☐ Hold objects ☐ Grip ☐ Type/Keyboard ☐ Write ☐ Other (specify)	**Limited ability to:** ☐ Bend ☐ Squat ☐ Kneel ☐ Twist ☐ Push ☐ Pull ☐ Other (specify)

☐ Limited Hearing or Vision	☐ Limit/Restrict Environmental exposure to: *(eg, heat, cold, noise or scents)*	☐ Potential side effects from medications that could impact return to work: *(please specify)*

Additional comments on Abilities and/or Restrictions:

Estimated duration of Limitations: _____ Complete recovery expected: _____

Date of next review or appointment:__ Recommend work hours: ☐ Yes ☐ No

Graduated Return Proposal:

	Hours/Day	Days/Week
Week 1		
Week 2		
Week 3		
Week 4		

Health Provider Name:

Signature:

Phone No.:

Date:

Attending Physician's Questionnaire – Mental Health Conditions

Section A	Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial)	Phone # (+ Area Code)	E-mail address

Address (Street, City, Province, Postal Code)

Employer's Name	Plan Contract #	Member Certificate #	Date of Birth (dd/mm/yyyy)

Date Last Worked (dd/mm/yyyy)	**Date Returned to Work or Expected Return to Work Date, if known** (dd/mm/yyyy)	**Please provide your:** Height:_____ Weight:_____

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. 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 may not be assessed. I understand that I am responsible for any fees related to the completion of this form. I agree that a copy or electronic version of this authorization shall be as valid as the original. **Medical and health information excludes genetic test results.**

Plan Member/Employee Signature — Date of Consent (dd/mm/yyyy)

Section B	Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR

I am the: Attending Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) _____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1) Diagnosis

Primary: _____

Secondary: _____

Is this condition related to: ☐ Occupational Illness/injury ☐ Auto accident If so, date of event: (dd/mm/yyyy) _____

Details: _____

Date of first visit to you pertaining to this condition: (dd/mm/yyyy)	First date of work absence due to this condition: (dd/mm/yyyy)

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

If yes, date: (dd/mm/yyyy) _____ By whom: _____

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.) _____

2) Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity:

3) Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy / Vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration / Focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect/Mood	☐	☐	☐	☐
Insight/Judgement	☐	☐	☐	☐
Self-Criticism	☐	☐	☐	☐

Observations or comments supporting the above:

4) Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

☐ Workplace Issues ☐ Social / Family Issues ☐ Financial / Legal Problems
☐ Physical Condition ☐ Alcohol / Drug Abuse ☐ Medication Side Effects
☐ Pain Perception ☐ Coping Skills ☐ Personality / Motivation ☐ Other

Please describe:

Please describe the supports in place, or planned, to assist with these issues:

5) 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

Are tests / investigations / consultations pending? Yes ☐ No ☐ Date report expected: (dd/mm/yyyy) _____

Does the patient have an appointment booked with any specialist(s) in the near future? Yes ☐ No ☐

Name of Specialist	Specialty	Date of Appt: (dd/mm/yyyy)
1.		
2.		

Reason for requesting the consultation: _____

Has any licence held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐ Don't Know ☐

If yes, as of when? (dd/mm/yyyy) _____ Type of licence: _____

6) Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response

7) Hospitalization

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

Date admitted (dd/mm/yyyy)	Date discharged (dd/mm/yyyy)	Institution Name
1.		
2.		

8) Treatment Details - Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

9) Treatment Details - Concurrent Physiological Disorders, if known (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

10) Overall Response to Treatment

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

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

Please explain: _____

_____

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

If so, please explain: _____

_____

11) Prognosis and Recovery

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

_____

_____

Please provide the patient's prognosis for improvement: _____

Please provide any other information that will help us understand the patient's current condition, recovery goals and prognosis:

_____

_____

_____

_____

Notice to Physician

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 (please print)	Physician's Specialty	Date Signed (dd/mm/yyyy)
Address:		Telephone # (+ area code) Fax # (+ area code)
Signature or Stamp		

PLEASE RETURN FORM TO:

The Wawanesa Life Insurance Company
400 - 200 Main Street, Winnipeg, MB R3C 1A8
Toll free: 1-844-318-0411 Fax: 1-855-496-3028
Email: Wawanesalife-claims@wawanesa.com Website: wawanesalife.com