

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

Attending Physician's Statement - Short-Term Disability Claim

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

Auto accident Yes No

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

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, we 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 impacting 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)	

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: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 100 meters <input type="checkbox"/> 100 – 200 meters <input type="checkbox"/> Other (specify)	Standing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 – 30 minutes <input type="checkbox"/> Other (specify)	Sitting: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes to 1 hr. <input type="checkbox"/> Other (specify)	Stair Climbing <input type="checkbox"/> None <input type="checkbox"/> 2 – 3 steps only <input type="checkbox"/> Short flight <input type="checkbox"/> Other (specify)	Drive a car: <input type="checkbox"/> Yes <input type="checkbox"/> No
Lifting floor to waist: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kg <input type="checkbox"/> 5 – 10 kg <input type="checkbox"/> Other (specify)	Lifting waist to shoulder: <input type="checkbox"/> < 5 kg <input type="checkbox"/> 5 – 9 kg <input type="checkbox"/> 10 – 25 kg <input type="checkbox"/> Other (specify)	Lifting/Reaching above shoulder: <input type="checkbox"/> < 5 kg <input type="checkbox"/> 5 – 9 kg <input type="checkbox"/> 10 – 25 kg <input type="checkbox"/> Other (specify)	Limited ability to: <input type="checkbox"/> Hold objects <input type="checkbox"/> Grip <input type="checkbox"/> Type/Keyboard <input type="checkbox"/> Write <input type="checkbox"/> Other (specify)	Limited ability to: <input type="checkbox"/> Bend <input type="checkbox"/> Squat <input type="checkbox"/> Kneel <input type="checkbox"/> Twist <input type="checkbox"/> Push <input type="checkbox"/> Pull <input type="checkbox"/> Other (specify)
<input type="checkbox"/> Limited Hearing or Vision		<input type="checkbox"/> Limit/Restrict Environmental exposure to: <i>(e.g., heat, cold, noise or scents)</i>		<input type="checkbox"/> Potential side effects from medications that could impact return to work: <i>(please specify)</i>

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: _____	
<p>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.</p>			
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 <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____			
PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE			
1) Diagnosis			
Primary: _____			
Secondary: _____			
Is this condition related to: <input type="checkbox"/> Occupational Illness/injury <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>			
If yes, date: (dd/mm/yyyy) _____ By whom: _____			
Have you completed any other disability claim forms recently for this patient? Yes <input type="checkbox"/> No <input type="checkbox"/>			
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy / Vigour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration / Focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affect/Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insight/Judgement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 license 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 license: _____

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 <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		

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 <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
			Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Other <input type="checkbox"/>		
10) Overall Response to Treatment					
Please describe the response to treatment to date: Complete <input type="checkbox"/> Partial <input type="checkbox"/> None <input type="checkbox"/> Too soon to tell <input type="checkbox"/>					
Is the patient following the recommended treatment program? Yes <input type="checkbox"/> No <input type="checkbox"/> Please explain: _____ _____					
Are there any plans to change or augment the current treatment program? Yes <input type="checkbox"/> No <input type="checkbox"/> 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