Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3875 succ. Lévis
Lévis (Québec) G6V 0A7
Fax: 418-835-0194
1-844-409-6575

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Physical Illnesses

Additional report

Note: For psychological illnesses, complete the form on the reverse. **The insured must complete this section.**

Last name and first name of the insured

Policy or group or contract no.	Certificate or identification no.	Date of birth Y Y Y Y M M D D

DECLARATION OF THE ATTENDING PHYSICIAN - Complete in block letters and give to the patient.

1. Diagnosis

1.1 Principal: _____

1.2 Secondary: _____

1.3 Objective elements of the physical examination and investigation (attach copy of recent results, X-rays, ECG, or other tests or examinations):

_____

_____

Weight: _____ lb ☐ kg ☐ Height: _____ ft/in ☐ m/cm ☐ Most recent blood pressure: _____

1.4 Degree of the symptom's severity (M = mild, Md = moderate, S = severe)

	M	Md	S		M	Md	S
_____	☐	☐	☐	_____	☐	☐	☐
_____	☐	☐	☐	_____	☐	☐	☐

2. Treatment

2.1 Drugs – name – dosage: _____

_____

2.2 Additional treatments (specify the type and frequency): _____

2.3 Surgery (date, nature and procedure): _____

2.4 Hospitalization: From _____ To _____ Name of hospital: _____

2.5 Consultation with a specialist: No ☐ Yes ☐ → **Attach copy.**

3. Follow-up and prognosis

3.1 Date of last consultation: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Tests and examinations to come: _____

3.3 Frequency of follow-up: _____

3.4 Referral to a specialist: No ☐ Yes ☐ Name of physician: _____

3.5 Scheduled date of consultation with a specialist: Y Y Y Y M M D D Specialty: _____

3.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability	Currently

3.7 Evolution: Progressive ☐ Stable ☐ Regressive ☐

3.8 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

_____

_____

3.9 Patient's cooperation in the treatment: Excellent ☐ Average ☐ Poor ☐

3.10 Would the patient benefit from assistance within the scope of a return to work? No ☐ Yes ☐

3.11 Approximate duration of the disability: No. of days: _____ No. of weeks: _____ Unspecified ☐ or date of return to work: Y Y Y Y M M D D

3.12 How long before the patient will be able to return to work? No. of days: _____ No. of weeks: _____

Part-time ☐ Full-time ☐ Gradual return ☐ Specify:

4. Additional information

_____

_____

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: ( )

5.2 License number: _____ Fax: ( )

General practitioner ☐ Specialist ☐ Specify: _____

Signature: **Date:** Y Y Y Y M M D D

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3875 succ. Lévis
Lévis (Québec) G6V 0A7
Fax: 418-835-0194
1-844-409-6575

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Psychological Illnesses

Additional report

Note: For physical illnesses, complete the form on the reverse. **The insured must complete this section.**

Last name and first name of the insured

Policy or group or contract no.	Certificate or identification no.	Date of birth (Y Y Y Y M M D D)

DECLARATION OF THE ATTENDING PHYSICIAN - Complete in block letters and give to the patient.

1. Diagnosis

1.1 Principal: _____

1.2 Secondary: _____

1.3 Please describe the signs and symptoms and indicate the frequency and their individual degree of severity (M = mild, Md = moderate, S = severe)

Signs	M	Md	S	Symptoms	M	Md	S
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

2. Treatment

2.1 Drugs – name – dosage: _____

2.2 **Is the patient consulting:**

			Since when?
a psychiatrist	No ☐	Yes ☐	
a psychologist	No ☐	Yes ☐	
a social worker	No ☐	Yes ☐	
an other caregiver	No ☐	Yes ☐	

Is the patient treated in:

			Specify:
a treatment centre	No ☐	Yes ☐	
a CLSC	No ☐	Yes ☐	
a day hospital	No ☐	Yes ☐	
group therapy	No ☐	Yes ☐	
individual therapy	No ☐	Yes ☐	

AXE II) Associated personality disorders: No ☐ Yes ☐ Specify: _____

Associated drug addiction, alcoholism or gambling problems: No ☐ Yes ☐ Specify: _____

AXE III) Associated illness: – diagnosis: _____

– drugs prescribed: _____

AXE IV) Associated psychosocial stress factors (in the last 12 months):

☐ Personal or interpersonal problems ☐ Loss of employment or layoff ☐ Professional problems

☐ Marital/family life ☐ Alcohol or drug abuse or gambling problems

☐ Other problems, specify: _____

AXE V) Global assessment of functioning (according to the GAF scale of the DSM IV (0 to 100) 100 = perfect condition)

– at the beginning of treatment _____ – currently _____

3. Follow-up and prognosis

3.1 Date of last consultation: (Y Y Y Y M M D D) Next consultation: (Y Y Y Y M M D D)

3.2 Follow-up frequency: _____

3.3 Will the patient be referred to a psychiatrist? No ☐ Yes ☐ Name of physician: _____

3.4 Patient's cooperation in the treatment: Excellent ☐ Average ☐ Poor ☐

3.5 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

_____

_____

3.6 Would your patient benefit from assistance within the scope of a return to work? No ☐ Yes ☐

3.7 Do you consider that the patient's condition has improved in an optimal way? No ☐ Yes ☐

3.8 Approximate duration of the disability: No. of days: ____ No. of weeks: ____ Unspecified ☐ or date of return to work: (Y Y Y Y M M D D)

3.9 How long before the patient will be able to return to work? No. of days: ____ No. of weeks: ____

Part-time ☐ Full-time ☐ Gradual return ☐ Specify:

4. Additional information

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: ( ) _____

5.2 License number: _____ Fax: ( ) _____

General practitioner ☐ Specialist ☐ Specify: _____

Signature: **Date:** (Y Y Y Y M M D D)

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.