

**1** Family name: \_\_\_\_\_ **2** Given name: \_\_\_\_\_  
**3** Contract no.: \_\_\_\_\_ Group or policy no. \_\_\_\_\_ **4** Certificate number: \_\_\_\_\_  
**5** 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)  

	<b>M</b>	<b>Md</b>	<b>S</b>		<b>M</b>	<b>Md</b>	<b>S</b>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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: \_\_\_\_\_ Y Y Y Y M M D D  
 3.5 Scheduled date of consultation with a specialist: \_\_\_\_\_ 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  Y Y Y Y M M D D  
 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. Questions specific to the contract**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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

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**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
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2. Treatment**

2.1 Drugs – name – dosage: \_\_\_\_\_

2.2 **Is the patient consulting:** Since when? **Is the patient treated in:** Specify:

a psychiatrist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	a treatment centre	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
a psychologist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	a CLSC	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
a social worker	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	a day hospital	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
an other caregiver	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	group therapy	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
				individual therapy	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____

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) General scale of functioning (according to the EGF 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. Questions specific to the contract**

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\_\_\_\_\_

**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