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ORIGINAL REQUEST SHORT TERM DISABILITY CLAIM

PSYCHOLOGICAL ILLNESSES - Physician's Form

Employee's Statement

Last Name:		First Name:
Client No. / Group No.	**GPM User ID / Certificate No.**	Social Insurance Nº.:
		Date of birth (dd/mm/yy):
Email Address:		

Declaration of the attending physician (Complete in block letters and give to the patient)

Diagnosis

Axis I: Axis III: GAF SCORE:

Axis II: Axis IV:

Current symptoms:

Degree of severity of all symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ With psychotic elements

Does the interruption of work result from problem related to: ☐ Marital or family life ☐ Loss of employment or layoff

☐ Professional problems ☐ Personal or interpersonal problems ☐ Alcohol or drug abuse or gambling problems

☐ Pregnancy ☐ Yes ☐ No ☐ Scheduled date of delivery (dd/mm/yy): ☐ Other problems, specify:

For the illnesses or associated symptoms diagnosed, has the patient previously: ☐ Received medical treatment

☐ Consulted another physician ☐ Received prescription drugs ☐ Been hospitalized ☐ Undergone examinations

Specify the dates of previous episodes:

Treatment

Name of prescription drugs - dosage:

Is the patient consulting:

Psychiatrist ☐ Yes ☐ No Psychologist ☐ Yes ☐ No Social worker ☐ Yes ☐ No

Another health care provider ☐ Yes ☐ No **If yes**, name of the caregiver consulted:

Other treatments, specify: Frequency/Comments:

Hospitalization (dd/mm/yy): from to Name of hospital:

Follow-up and prognosis

Date of the first consultation (dd/mm/yy): Date of the next consultation (dd/mm/yy):

Date of the last consultation (dd/mm/yy): Other dates of consultations: Follow-up frequency:

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

Approximate duration of disability - Nº. of days: Nº. of weeks: ☐ Unspecified Date of return to work (dd/mm/yy):

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:

Questions specific to the contract

During the last five years, has the patient consulted or been treated by a physician or another practitioner, or taken prescription drugs prescribed by a physician for one of the following illnesses or conditions: cancer or tumor, diabetes, hypertension, Crohn's disease, ulcerative colitis, hepatitis, heart diseases or blood vessel disorders, drug addiction or alcoholism, nervous or mental disorders, pulmonary disorders, renal or urinary problems, cerebral or neurological problems, disorders related to the spine, illnesses related to AIDS? Has the patient undergone an analysis showing the presence of HIV antibodies?

☐ Yes ☐ No **If yes**, please indicate the following information:

Illnesses	**Dates** (dd/mm/yy)	**Results**	**Periods of hospitalization**	**When was the patient informed of this illness?** (dd/mm/yy)

Others:

Identification of the physician

Last and First Name: Telephone: Fax:

License Nº.: ☐ General Practitioner ☐ Specialist Specify:

Signature: Date (dd/mm/yy):

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