ATTENDING PHYSICIAN'S STATEMENT
ADDITIONAL REPORT

SSQ, Life Insurance Company Inc. | Disability Management & Life Insurance
2525 Laurier Boulevard | P.O. Box 10500 | Station Sainte-Foy | Quebec (Quebec) G1V 4H6
418-651-2307 or 1-888-651-2307 | Fax: 418-651-5569

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

Section 1 – Plan Member/Employee Information and Consent — TO BE COMPLETED BY PATIENT

☐ Male
☐ Female

Plan Member/Employee Name : _____
Last Name First Name

Date of Birth (Y Y A A | M M | D D)

Home Phone # (+ Area Code)

Cell Phone # (+ Area Code)

Address _____
Street City Province Postal Code

Employer's Name

Plan Contract #

Member Certificate #

Date Last Worked (Y Y Y Y | M M | D D)

Date Returned to Work or Expected Return to Work Date (Y Y Y Y | M M | D D)

Please list your present medications:

Name of Medication	Dosage (mg)	How Often?
1.		
2.		
3.		
4.		
5.		

Please provide your:
Height: _____
Weight: _____

Dominant Hand:
Left ☐
Right ☐

Section 2 – Attending Physician's Statement — TO BE COMPLETED BY PHYSICIAN

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

1) Diagnosis

Primary: _____

Secondary and/or Complications: _____

If Childbirth – Expected or Actual Delivery Date (Y Y Y Y | M M | D D)

Is this condition due to:

Occupational Illness/injury
☐ Yes ☐ No
If yes, date of event: (Y Y Y Y | M M | D D)

Auto accident
☐ Yes ☐ No
If yes, date of event: (Y Y Y Y | M M | D D)

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.) _____

Date of first visit to you pertaining to this condition (Y Y Y Y | M M | D D)

First date of work absence due to condition (Y Y Y Y | M M | D D)

2) Treatment

e.g. Special Programs, Therapies, Medications:

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: Y Y Y Y M M D D Date of the next visit: Y Y Y Y M M D D

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

If yes, date: Y Y Y Y M M D D

Treatment Provider: _____

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

Please elaborate: _____

3) Response to Treatment

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

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

If so, please explain: _____

4) Hospitalization

Is/was the patient hospitalized? ☐ Yes ☐ No

Is future hospitalization planned? ☐ Yes ☐ No

	Date of admittance	Date of discharge	Institution Name
1.	Y Y Y Y M M D D	Y Y Y Y M M D D	
2.	Y Y Y Y M M D D	Y Y Y Y M M D D	
3.	Y Y Y Y M M D D	Y Y Y Y M M D D	

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date	Description
1.	Y Y Y Y M M D D	
2.	Y Y Y Y M M D D	
3.	Y Y Y Y M M D D	

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)**
- **consultation reports**

Are tests/investigations pending ☐ Yes ☐ No

	Date	Description
1.	Y Y Y Y M M D D	
2.	Y Y Y Y M M D D	

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future? ☐ Yes ☐ No

	Name of Specialist	Specialty	Date
1.			Y Y Y Y M M D D
2.			Y Y Y Y M M D D

6) Clinical Findings and Observations

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

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

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Comments:

7) Restrictions and Limitations

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

Has any license held by the patient been restricted or revoked as a result of this condition? ☐ Yes ☐ No

If yes, as of when? Y Y Y Y M M D D Type of license:

Do you have concerns about the patient's ability to manage his/her own affairs? ☐ Yes ☐ No

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals?

☐ Yes ☐ No

Please elaborate: _____

8) Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

9) Return-to-work

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

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

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

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 _____

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 _____ Date Signed : Y Y Y Y M M D D
(please print)

Physician's Specialty _____ License Number: _____

Address: _____ _____ _____ _____
Street City Province Postal Code

Telephone # (+ area code): _____ Fax # (+ area code): _____

Signature: _____