SSQ Financial Group

*Values in the right place*

# ATTENDING PHYSICIAN'S STATEMENT ADDITIONAL REPORT

SSQ, Life Insurance Company Inc. | Disability Management & Life Insurance
110 Sheppard Ave. East, Suite 500 | Toronto ON M2N 6Y8
1-866-885-6772 | Fax: 1-866-411-9248

**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 ☐ Consulting 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: (if not noted by patient in **Section 1**)

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

Date of last 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 or augment 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

Please describe the patient's symptoms including history, severity and frequency:

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

## 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:

## 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: _____