La Capitale

LONG-TERM CARE
ATTENDING PHYSICIAN'S STATEMENT

Insured's last name

Insured's first name

Date of birth: Year Month Day

Sex: ☐ F ☐ M

Contract No.

Client No.

THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED FOR COMPLETING THIS FORM.

When disclosing medical and health information, the results of any genetic test should not be included.

DIAGNOSIS

1 Primary diagnosis: _____ Date of diagnosis: Year Month Day

2 Secondary diagnosis: _____ Date of diagnosis: Year Month Day

3 Date of last consultation: Year Month Day

4 Reason for consultation: _____

STATE OF DEPENDENCY

5 Is the insured usually unable, **without the help of another person**, to perform the following activities of daily living?

5.1 Feeding: The ability to consume, with or without the use of adaptive utensils, food and drink prepared and served by others. ☐ Yes ☐ No

Start of inability, if applicable: Year Month Day

Details: _____

5.2 Bathing: The ability to wash oneself in a bath or shower, including entering into and exiting from the bath or shower, or by a sponge bath, in such a way that an acceptable degree of hygiene is maintained. ☐ Yes ☐ No

Start of inability, if applicable: Year Month Day

Details: _____

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IND226E (04-2020)

STATE OF DEPENDENCY (cont.)

5.3 Dressing: The ability to put on or take off all necessary items of clothing and any medically necessary braces, surgical appliances or artificial limbs. Any item of clothing that can be made, purchased, or purchased and altered and that is reasonable for the insured's health, comfort and dignity in the environment in which he or she normally lives constitutes "necessary items of clothing." ☐ Yes ☐ No

Start of inability, if applicable: _____ (Year) ____ (Month) ____ (Day)

Details: _____

5.4 Transferring: The ability to move toward a bed, to get into and out of bed, and the ability to sit in a chair or a wheelchair and to get up from it with or without the assistance of auxiliary equipment. ☐ Yes ☐ No

Start of inability, if applicable: _____ (Year) ____ (Month) ____ (Day)

Details: _____

5.5 Toileting: The ability to get to and from, on and off the toilet, and perform the associated personal hygiene. ☐ Yes ☐ No

Start of inability, if applicable: _____ (Year) ____ (Month) ____ (Day)

Details: _____

5.6 Continence: The ability to control bowel and bladder functions voluntarily, with or without surgical appliances or protection from incontinence, in such a way that an acceptable degree of hygiene is maintained. ☐ Yes ☐ No

Start of inability, if applicable: _____ (Year) ____ (Month) ____ (Day)

Details: _____

COGNITIVE IMPAIRMENT

6 Has cognitive impairment been diagnosed? ☐ Yes ☐ No

6.1 If so, what is the diagnosis? _____

6.2 Date of diagnosis: _____ (Year) ____ (Month) ____ (Day)

6.3 Tests and examinations performed to confirm this diagnosis:

6.3.1 _____

6.3.2 _____

7 Which sentence below best describes the degree of the insured's cognitive impairment?
☐ The insured has moderate cognitive impairment and does not require monitoring.
☐ The insured has severe cognitive impairment and requires constant monitoring to ensure his or her health and safety.

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IND226E (04-2020)

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COGNITIVE IMPAIRMENT (cont.)

8 Additional information: _____

_____

_____

_____

ATTENDING PHYSICIAN'S SIGNATURE AND CONTACT INFORMATION

Signed at _____ on this _____ day of _____ 20 _____ .

X _____ _____

Attending physician's signature | Attending physician's full name (please print)

☐ General practitioner ☐ Specialist – Specify: _____ Licence No.: _____

_____ _____

Address (No., street, city, province) | Postal code

_____ _____

Area code | Telephone

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IND226E (04-2020)