

**Short Term Disability
Attending Physician's Statement**



SECTION 1 - TO BE COMPLETED BY PLAN MEMBER

THE PATIENT IS RESPONSIBLE FOR ANY CHARGE INVOLVED FOR THE COMPLETION OF THIS FORM

Plan Sponsor – Name _____ Policy #/Division/Class OR Control # _____ Division Name (if appropriate) _____

Patient – Last Name _____ First Name and Initial _____ Date of Birth (dd/mm/yy) _____

Patient – Address No. _____ Street _____ City _____ Province _____ Postal Code _____

I hereby authorize the release of any information in respect to this claim to The Maritime Life Assurance Company

Patient's Signature (in full) _____ (dd/mm/yy) _____

SECTION 2 - TO BE COMPLETED BY ATTENDING PHYSICIAN

Please provide all information and documentation as requested on this form so that we can better understand the extent of your patient's condition and the resulting impairments. The information provided will form the basis upon which entitlement to benefits will be assessed.

Physician – Last Name _____ First Name and Initial _____ Specialty _____

Physician – Address No. _____ Street _____ City _____ Province _____ Postal Code _____

Telephone Number (including area code) _____ Fax Number (including area code) _____ Physician Email Address _____

1. DIAGNOSIS

- a) Primary _____
- b) DSM IV terminology and codes: Axis I _____
 Axis II _____ Axis III _____
 Axis IV _____ Axis V _____
- c) Secondary _____
- d) Is condition due to injury or sickness arising out of patient's employment? No Yes Unknown
- e) Please enclose copies of the following documents in support of the stated diagnosis:
 consultation notes test/investigation reports assessment reports psychological testing reports operative reports
 hospital admission history discharge summary clinical notes other _____

2. SYMPTOMS & FINDINGS

- a) To the best of your knowledge indicate when symptoms first appeared or accident happened _____ (dd/mm/yy)
- b) Has patient had same or similar condition? No Yes If yes, please state when and describe _____
- c) Please state all current symptoms on which your diagnosis is based _____
- d) Objective findings _____

3. CURRENT IMPAIRMENTS

a) PHYSICAL

- i) Class 1 (no impairment - capable of strenuous physical activity)
 Class 2 (slight limitation - capable of moderate activity)
 Class 3 (moderate limitation - capable of light activity)
 Class 4 (marked limitation - capable of minimal activity)
 Class 5 (severe limitation - incapable of minimal activity)
- ii) Is your patient capable of:
 Lifting _____ kgs. / lbs
 Sitting Standing
 Walking Bending
 Squatting Climbing
- iii) Is your patient: Ambulatory House Confined Bed Confined Hospital Confined
- iv) Does your patient require assistive devices? If yes, please specify _____

b) PSYCHIATRIC

- i) Class 1 (able to function under stress and engage in interpersonal relationships - no limitation)
 Class 2 (able to function in most stress situations and engage in most interpersonal relationships - slight limitations)
 Class 3 (able to engage in only limited stress situations and limited interpersonal relationships - moderate limitation)
 Class 4 (unable to engage in stress situations or engage in interpersonal relationships - marked limitation)
 Class 5 (patient has significant loss of psychological and social abilities - severe limitation)
- ii) How does your patient's psychiatric disorder affect his/her ability to work? Please provide specific restrictions and limitations

SECTION 2 - (CONT'D)**4. COMPLICATIONS**

- a) Please indicate any medical complications which are delaying your patient's recovery _____
- b) Other factors influencing condition (for example - work issues, job loss, relationships, bankruptcy, family illness/death, loss of professional licence, etc.) _____
- c) Is there an alcohol or substance abuse problem? No Yes If yes, please specify treatment centre and program details _____

5. TREATMENT

- a) Current medications. Please specify names of drugs, dosages, start dates, duration, and frequency. _____
- Response to treatment: _____
- b) Other treatment - for example, physiotherapy, counseling, day treatment programs. Please specify type, frequency and full name of facility _____
- Response to treatment _____
- c) Dates hospitalized (recent) Admission Date _____ Discharge Date _____
(dd/mm/yy) Reason (dd/mm/yy)
 Institution _____
- d) Compliance: Is your patient following the recommended treatment program? No Yes If no, please explain _____
- e) Please state frequency of visits: weekly monthly other, please specify _____
- f) Date of first and all subsequent visits during present period of absence from work _____
(dd/mm/yy)
- g) Please provide details of any proposed treatment plan including any recommended surgery _____
- h) Have you referred your patient to any other physician? No Yes If yes, please provide the full name and specialty _____

6. PROGNOSIS

- a) What do you understand your patient's occupation to be? _____
- b) Are you familiar with the requirements of your patient's occupation? No Yes
- c) Has your patient expressed a desire to return to work? No Yes If yes, please comment _____
- d) What are your patient's specific work restrictions/limitations? _____
- e) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of the present condition. " _____ to _____ inclusive"
(dd/mm/yy) (dd/mm/yy)

7. COMPETENCY

Is your patient competent to endorse cheques and direct the use of the proceeds? No Yes If no, from what date? _____
(dd/mm/yy)

8. LICENCE RESTRICTION

Has your patient's professional licence, certification, driver's or other licence been restricted suspended revoked
 If yes, date _____ Type of licence _____ Class of licence (if applicable) _____
(dd/mm/yy)

9. REMARKS

- a) Additional remarks _____
- b) Have you provided medical information on your patient's behalf for other benefits? If yes, please provide the full name of the company _____

SECTION 3 - PHYSICIAN DECLARATION

I DECLARE that the information in this statement is true to the best of my knowledge.

Physician Signature (in full) _____

_____ (dd/mm/yy)