BLUE CROSS® CANASSURANCE

Attending Physician's Statement Additional Report

Psychological Illness

For physical illness, complete the other side of this form.

IDENTIFICATION (the insured must complete this section)

Last Name: _____ First Name: _____ Date of Birth: _____
Policy No: _____ Public Health Insurance No: _____

ATTENDING PHYSICIAN'S STATEMENT (complete in block letters and give to the patient)

1. DIAGNOSIS

1.1. Primary: _____ Code CIM-9: _____
1.2. Secondary: _____ Code CIM-9: _____
1.3. Please describe the signs and symptoms and indicate the frequency and their individual degree of severity (M=mild, Md=moderate, S=severe)

Signs	M	Md	S	Symptoms	M	Md	S
_____	❑	❑	❑	_____	❑	❑	❑
_____	❑	❑	❑	_____	❑	❑	❑
_____	❑	❑	❑	_____	❑	❑	❑

2.TREATMENT

2.1. Medication – name and dosage: _____
2.2. Is the patient consulting a:

		Provide dates	Is the patient treated:		Specify
psychiatrist	❑ yes ❑ no	_____	in a treatment centre	❑ yes ❑ no	_____
psychologist	❑ yes ❑ no	_____	in a medical clinic	❑ yes ❑ no	_____
social worker	❑ yes ❑ no	_____	in a day hospital	❑ yes ❑ no	_____
other caregiver	❑ yes ❑ no	_____	in group therapy	❑ yes ❑ no	_____
			in individual therapy	❑ yes ❑ no	_____

AXIS II) Associated personality disorders? ❑ yes ❑ no Specify: _____
Associated drug addiction, alcoholism or gambling problems? ❑ yes ❑ no Specify: _____

AXE III) MalaAXIS III) Associated illness: — diagnosis:
— drugs prescribed: _____

AXIS IV) Associated psychological stress factors (in the last 12 months):
❑ marital/family life ❑ loss of employment or layoff ❑ professional problems
❑ personal or interpersonal problems ❑ alcohol or drug abuse and/or gambling problems
❑ other problems, specify: _____

AXIS V) General scale of functioning (according to the GAF scale of the DSM IV (0 to 100) 100=perfect condition)
— at the beginning of treatment: _____ — currently: _____

3. FOLLOW-UP AND PROGNOSIS

3.1. Date of last consultation for this disability: _____ Date of next consultation: _____
3.2. Frequency of follow-up: _____
3.3. Has the patient been, or will be, referred to a psychiatrist? ❑ yes ❑ no Name of physician: _____
3.4. Patient's cooperation in the treatment: ❑ excellent ❑ average ❑ poor
3.5. If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

_____
_____
_____

3.6. Would your patient benefit from assistance within the scope of a return to work? ❑ yes ❑ no
3.7. Do you consider that the patient's condition has improved in an optimal way? ❑ yes ❑ no
3.8. Approximate duration of disability: ____days _____ weeks ❑ To be determined or date of return to work: _____
3.9. When will this patient be able to return to work? _____ days _____ weeks
❑ part-time ❑ full-time ❑ gradual return Please specify: _____

4. COMMENTS - Please add any comments that would help us better understand your patient's medical condition.

_____
_____
_____
_____

STATEMENT

First and Last name: _____ Telephone: _____
Address: _____ Fax: _____
❑ General practitioner ❑ Specialist Please specify: _____ Licence No: _____
Signature: _____ Date: _____ day /month/ year

Note: The claimant must pay any fees requested to complete this form.

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Physical Illness

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IDENTIFICATION (the insured must complete this section)

Last name: _____ First Name: _____ Date of Birth: _____
Policy No: _____ Public Health Insurance No: _____

ATTENDING PHYSICIAN'S STATEMENT (complete in block letters and give to the patient)

1. DIAGNOSIS

1.1. Primary: _____ Code CIM-9: _____
1.2. Secondary: _____ Code CIM-9: _____
1.3. Objective elements of the physical examination and investigation (attach copy of recent results, x-rays, ECG, or other tests or examinations):

_____

_____

Weight: ❑ lb ❑ kg Height: ❑ ft/in ❑ m/cm Most recent blood pressure: _____

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

	M	Md	S		M	Md	S
_____	❑	❑	❑	_____	❑	❑	❑
_____	❑	❑	❑	_____	❑	❑	❑

2.TREATMENT

2.1. Medication – name and dosage: _____

_____

2.2. Additional treatments (specify the type and frequency): _____
2.3. Surgery (date, nature and procedure): _____
2.4. Hospitalization from: _____ to _____ Name of hospital: _____
2.5. Consultation with a specialist: ❑ yes ❑ no **Attach copy**

3. FOLLOW-UP AND PROGNOSIS

3.1. Date of last consultation for this disability: _____ Date of next consultation: _____
3.2. Tests and examinations to come: _____
3.3. Frequency of follow-up: _____
3.4. Referral to a specialist: ❑ yes ❑ no Name of physician: _____
3.5. Scheduled date of consultation with a specialist: _____ Specialty: _____
3.6. Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability	Currently
_____	_____
_____	_____

3.7. Evolution: ❑ progressive ❑ stable ❑ regressive
3.8. If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

_____

_____

3.9. Patient's cooperation in the treatment: ❑ excellent ❑ average ❑ poor
3.10. Would your patient benefit from assistance within the scope of a return to work? ❑ yes ❑ no
3.11. Approximate duration of disability: _____days _____weeks ❑ To be determined or date of return to work: _____
3.12. How long before the patient will be able to return to work? _____days _____weeks
❑ part-time ❑ full-time ❑ gradual return Specify: _____

4. COMMENTS - Please add any comments that would help us better understand your patient's medical condition.

_____

_____

_____

_____

_____

STATEMENT

First and Last name: _____ Telephone: _____
Address: _____ Fax: _____
❑ General practitioner ❑ Specialist Please specify: _____ Licence No: _____
Signature: _____ Date: _____ day /month/ year

Note: The claimant must pay any fees requested to complete this form.