SSQ Financial Group

Values in the right place

ATTENDING PHYSICIAN'S QUESTIONNAIRE MENTAL HEALTH CONDITIONS

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 charge made for the completion of this form.

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

☐ Male
☐ Female

Plan Member/Employee Name: _____
Last Name First Name

Phone # (+ Area Code) _____

Date of Birth (Y Y Y Y M M D D) _____

E-mail address _____

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, if known (Y Y Y Y M M D D) _____

Please provide your:

Height: _____ Weight: _____

Section B – Attending Physician's Questionnaire — TO BE COMPLETED BY PHYSICIAN

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

1) Diagnosis

Primary: _____

Secondary: _____

Is this condition related to: Occupational Illness/injury ☐ Auto accident ☐

If so, date of event: (Y Y Y Y M M D D) _____

Details: _____

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 this condition (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) _____ By whom: _____

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.) _____

2) Patient's Description of Symptoms

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

3) Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy / Vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration / Focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect/Mood	☐	☐	☐	☐
Insight/Judgement	☐	☐	☐	☐
Self-Criticism	☐	☐	☐	☐

Observations or comments supporting the above:

4) Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

☐ Workplace Issues ☐ Social / Family Issues ☐ Financial / Legal Problems

☐ Physical Condition ☐ Alcohol / Drug Abuse ☐ Medication Side Effects

☐ Pain Perception ☐ Coping Skills ☐ Personality / Motivation ☐ Other

Please describe:

Please describe the supports in place, or planned, to assist with these issues:

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 / consultations pending? ☐ Yes ☐ No Date report expected: Y Y Y Y M M D D

Does the patient have an appointment booked with any specialist(s) in the near future? ☐ Yes ☐ No

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

Reason for requesting the consultation: _____

Has any license held by the patient been restricted or revoked as a result of this condition? ☐ Yes ☐ No ☐ Don't Know

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

6) Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started		Current dosage and date changed if applicable	Response
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	

7) Hospitalization

Is/was the patient hospitalized? ☐ Yes ☐ No

Is future hospitalization anticipated? ☐ Yes ☐ No

	Date admitted	Date discharged	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	

8) Treatment Details - Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began	Frequency of visits	Date of last visit	Response
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Weekly ☐ Monthly ☐ Other ☐	Y Y Y Y M M D D	

9) Treatment Details - Concurrent Physiological Disorders, if known (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began	Frequency of visits	Date of last visit	Response
		Y Y Y Y M M D D	☐ Weekly ☐ Monthly ☐ Other	Y Y Y Y M M D D	
		Y Y Y Y M M D D	☐ Weekly ☐ Monthly ☐ Other	Y Y Y Y M M D D	
		Y Y Y Y M M D D	☐ Weekly ☐ Monthly ☐ Other	Y Y Y Y M M D D	
		Y Y Y Y M M D D	☐ Weekly ☐ Monthly ☐ Other	Y Y Y Y M M D D	

10) Overall Response to Treatment

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

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

Please explain: _____

_____

_____

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

If so, please explain: _____

_____

11) Prognosis and Recovery

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

_____

_____

Please provide the patient's prognosis for improvement: _____

Please provide any other information that will help us understand the patient's current condition, recovery goals and prognosis:

_____

_____

_____

_____

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: _____