PHYSICIAN'S INITIAL REPORT FORM

Part 2 – Identification and Authorization *Part 2 to be completed by Member.*

Name and Address of Insurer: **SGEU Long Term Disability Plan**	Address of Insurer: **1011 Devonshire Dr N Regina, SK S4X 2X4**	
Name of the Plan's Medical Adjudicator* **Blue Cross** *Subject to appointment from time to time.		
Last Name of Member First Name Initial	**Member's DOB (y/m/d)**	**Member's S.I.N.**
I hereby authorize the release to my insurer and to my policy holder of any information in respect to the settlement of this claim. **Member's Signature** **Date (y/m/d)**		

Part 3 – History and Findings

To provide further information on any physical disability or a mental health or emotional disability, complete the applicable portions of this form and attach a narrative statement.

3.1 Mechanism of injury or onset of illness	
3.2 To the best of my knowledge, the illness started or the injury happened on (y/m/d).	**3.3 To the best of my knowledge, the Member has been unable to work as a result of the disability from (y/m/d).**
3.4 Date of first examination / treatment for the present condition (y/m/d).	3.5 Dates of hospitalization (y/m/d) From To Name of hospital
3.6 Physical findings	
3.7 Diagnostic tests ordered	3.8 Findings from diagnostic tests (Attach copies of all results.)

Part 4 – Diagnosis

4.1 Diagnosis of Physical Illness or Injury	4.2 Diagnosis of Mental or Emotional Illness Is This A Workplace Issue? ☐ Yes ☐ No

Part 5 – Management Plan

5.1

[ ] Active treatment is required - Next Appointment Scheduled (y/m/d) _____

[ ] No Active treatment is required

5.2 Treatment initiated: (specify in each case)

Medications _____

Exercise/Therapy _____

Education/Other Treatment _____

The medication(s) might impair safety in the workplace for the Member or for others as follows:

5.3 Referred for assessment/treatment to (specify name and date):

[ ] Medical/Surgical Specialist _____

[ ] Psychiatrist _____

[ ] Counsellor _____

[ ] Physical Therapist _____

[ ] Other Therapist _____

[ ] Chiropractor _____

[ ] Other Referral _____

5.4 To the best of my knowledge, the Member is prepared to follow the above management plan.

[ ] Yes [ ] No (If no, explain why not.)

Part 6 – Activity Level and Prognosis

6.1 The Member is currently working? Yes **[ ]** No **[ ]** Participating in activities of daily living? Yes **[ ]** No **[ ]**

6.2 The Member is unable to participate in normal activities, including work, because of limitations in one or more of the following areas (provide explanation):

[ ] Standing _____

[ ] Sitting _____

[ ] Lifting _____

[ ] Turning _____

[ ] Mental Function _____

[ ] Allergies _____

[ ] Work Environment _____

[ ] Other _____

6.3 The disability may affect activity for: Over 119 calendar days **[ ]** Unknown **[ ]**

6.4 Permanent scarring or disfigurement Yes **[ ]** No **[ ]**	6.5 Permanent functional disability is possible Yes **[ ]** No **[ ]**

Part 7 – Past History and Other Conditions

7.1 Other factors that might effect the duration of the current disability are: Addictions **[ ]** Pre-existing medical conditions **[ ]** Environmental **[ ]** Physical Fitness **[ ]** Family **[ ]** Dietary **[ ]** Other medical conditions **[ ]** Employment **[ ]** Psychosocial **[ ]** Other **[ ]** The specifics of the above indicated factors are:
7.2 The Member previously had the same or similar condition as follows:
7.3 The following remarks might be helpful or important to explain the Member's recovery and return to work:

Part 8 – Rehabilitation

	For Own Occupation	For Any Other Occupation
8.1 Is Member a suitable candidate for trial employment?	Yes **[ ]** No **[ ]**	Yes **[ ]** No **[ ]**
8.2 If "YES", when could trial employment commence?		
[ ] Part–time	yy/mm/dd	yy/mm/dd
[ ] Full–time	yy/mm/dd	yy/mm/dd
8.3 If "NO", provide explanation:		
8.4 Would vocational rehabilitation be recommended: Yes **[ ]** No **[ ]**		

Part 9 – Attending Physician (NOTE: Physician's Stamp Must Be Affixed Below.)

Last Name First Name Initial		**Practitioner/Payee Number**
Street Address	Phone No.	Fax No.
Town/City	Province	Postal Code
Signature		**Date yy/mm/dd**

Attending Physician - Please ensure *Practitioner/Payee Number* is entered and that form is **signed and dated**.

Thank you

NOTE: It is the Claimant's responsibility to pay for any costs incurred for the completion of this document.