SGEU LTD Plan
1011 Devonshire Dr. N.
Regina, SK. S4X 2X4
FAX: (306)775-5775

Claim for SGEU Long Term Disability Benefits Physician's Initial Report

Instructions:

The Patient is responsible for any fees related to the completion of this form

Return this form to your patient for submission to the SGEU LTD Plan

Part 1 – Identification and Authorization: To be completed by Member / Patient

Member's Name (Last, First, Middle Initial)	**Home Phone:**	**Cell Phone:**

Address (Box number, Street, City, Province, Postal Code)

Date of Birth (mm/dd/yy)	**Height**	**Weight**

Last Date Worked (mm/dd/yy)	**Date Returned to Work or Expected Return to Work Date (mm/dd/yy)**

I authorize the release of personal information and personal health information in my file by the healthcare provider listed on this form to the SGEU LTD Plan and/or the Plan's third-party medical adjudicator, and/or any of its authorized agents or representatives for the purposes of determining eligibility for coverage, claims adjudication and payment. This information includes, but is not limited to, copies of consultation reports, my medical history, clinical notes, test results and hospital records.

I understand that my personal health information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

Member's Signature	**Date (mm/dd/yy)**

Part 2 – To be Completed by the Physician (or Nurse Practitioner Where Applicable)

Primary Diagnosis

Secondary and/or Complications

Date of first visit to you pertaining to this condition (mm/dd/yy)	**First date of work absence (if known) due to this condition** (mm/dd/yy)

Occupational (Workplace) Illness/Injury Yes ☐ No ☐ If yes, date of event: (mm/dd/yy)	**Auto Accident** Yes ☐ No ☐ If yes, date of event: (mm/dd/yy)

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Part 3 – 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
- Do not provide generic test results

Are any tests/investigations pending? Yes ☐ No ☐

	Date (mm/dd/yy)	Description
1.	_____	_____
2.	_____	_____

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (mm/dd/yy)
1.	_____	_____	_____
2.	_____	_____	_____

Clinical Findings and Observations

A) Describe patient's symptoms, severity, and frequency.

B) Provide a summary of objective examination findings and clinical observations.

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Regressed ☐

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

Are there other complicating factors that may impact the patient's expected recovery period and return-to-work?

Yes ☐ No ☐

☐ Addictions	☐ Social/Family Issues	☐ Financial/Legal Problems	☐ Pre-existing Medical Condition
☐ Physical Conditions	☐ Alcohol/Drug Abuse	☐ Medication Side Effects	☐ Work Environment
☐ Pain Perception	☐ Coping Skills	☐ Personality/Motivation	☐ Other

Please elaborate including a description of any supports in place, or planned, to assist with these barriers:

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Prognosis
Please provide the patient's prognosis for improvement and / or recovery:

Return-to-Work
What return-to-work goals have been discussed with the patient? Please elaborate:

Part 4 – Treatment

☐ **No active treatment is required.**

Current Treatment: (e.g. Special Programs and therapies)

	Treatment start date (mm/dd/yy)	Frequency	End date (if known) (mm/dd/yy)
☐ Medical/Surgical Specialist			
☐ Psychiatrist			
☐ Psychologist			
☐ Counsellor (social work / mental health worker)			
☐ Physical / Exercise Therapist			
☐ Chiropractor			
☐ Education / Other Treatment Problems			
☐ Other			

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (mm/dd/yy) _____

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date: (mm/dd/yy) _____ Treatment Provider: _____

List all prescribed medications (dosage/frequency/start date):

	Name of Medication	Dosage (mg)	Frequency	Start Date (mm/dd/yy)	End Date (mm/dd/yy)
1.					
2.					
3.					
4.					
5.					

List previous medications trialed and general response:

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Do the medication(s) impair safety in the workplace for the patient or for others? Yes ☐ No ☐

Has the patient been fully compliant with the prescribed treatment plan? ☐ Yes ☐ No

If no, explain:

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

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

If yes, please explain:

Part 5 - Hospitalization

Is/was the patient hospitalized? ☐ Yes ☐ No **Is future hospitalization planned?** ☐ Yes ☐ No

	Date of admittance	Date of discharge	Institution name
1.			
2.			
3.			

If surgery was / will be performed, please provide date(s) and description of surgery(s):

	Date (mm/dd/yy)	Description
1.		
2.		
3.		
4.		
5.		

Part 6 - Return to Work – Restrictions / Limitations

Is the Patient currently working? ☐ Yes ☐ No **Participating in activities of daily living?** ☐ Yes ☐ No

Is the Patient fit to return to modified / alternate duties? ☐ Yes ☐ No
If yes, provide estimated date (mm/dd/yy): _____

If 'Yes' in questions above, does the Patient have:

☐ Physical Restrictions / Limitations (Fill in Part 7.1 Physical Restrictions / Limitations Section)

☐ Cognitive or Psychological Restrictions / Limitations (Fill in 7.2 Cognitive / Psychological Restrictions Section)

If 'No' in question above, please explain in detail the medical contraindications, concerns or functional limitations which preclude your patient from participating in any employment activities at this time.

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Part 7 - Restrictions / Limitations

7.1 PHYSICAL LIMITATIONS		Hours at one time					Total hours during 8 hr. day				
		<1	1-2	2-4	4-6	6-8	<1	1-2	2-4	4-6	6-8
Sitting	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Standing	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ladder and Stair Climbing	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kneeling/Crawling Crouching	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Driving/Operate Vehicle	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

This patient can lift/carry a maximum of: _____kgs. _____lbs.		0kgs 0lbs	5kgs 10lbs	9kgs 20lbs	14kgs 30lbs	18kgs 40lbs	23kgs 50lbs	27kgs 60lbs	32kgs 80lbs	36kgs 80lbs	41+kgs 90+lbs
☐ No Restriction	☐ Repetitively – how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally – how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Reaching / Repetitive Arm Movements ☐No Restriction	Left Arm limited to: ☐ below waist ☐ waist level ☐ chest level Right Arm limited to: ☐ below waist ☐ waist level ☐ chest level
Manual Dexterity (Grip / Twist / Keyboarding) ☐No Restriction	☐ Left hand / arm ☐ Right hand / arm ☐ Fine motor skills (pick up small items; writing; using computer mouse) ☐ Gripping / twisting / pulling ☐ Keyboarding: Limit to _____hrs / day

In your opinion, does the patient have any cognitive or psychological difficulties that could negatively impact their ability to work and/or their performance within the workplace? If yes, fill below.

7.2 COGNITIVE / PSYCHOLOGICAL LIMITATIONS	Level of impairment			
	No Impact	Mild	Moderate	Severe
Memory processing or recalling information	☐	☐	☐	☐
Concentration/focus	☐	☐	☐	☐
Comprehending new information	☐	☐	☐	☐
Problem-solving	☐	☐	☐	☐
Complex numerical calculations	☐	☐	☐	☐
Insight/judgement	☐	☐	☐	☐
Analyzing information/data	☐	☐	☐	☐
Completing tasks with frequent interruptions	☐	☐	☐	☐
Tolerating unusual and shifting deadline pressures	☐	☐	☐	☐
Socialization/handling conflict	☐	☐	☐	☐
Experiences excessive mental fatigue every day	☐	☐	☐	☐
Experiences excessive physical fatigue every day	☐	☐	☐	☐

Observations or comments supporting the above:

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Part 8 – Attending Physician (NOTE: Physician's Stamp Must Be Affixed Below.)		
The information in this statement will be kept in a disability benefits file with the SGEU LTD Plan and third-party medical adjudicator and may be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.		
Attending Physician (please print)	**Practitioner Number**	**Physician's Stamp**
Address (Street, City, Province, Postal Code)		
Telephone # (+Area Code)	Fax # (+Area Code)	
Email Address		
Signature	**Date Signed (mm/dd/yy)**	

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