PHYSICIAN'S INITIAL REPORT FORM

Instructions:

Part 2 - To be completed by Member

Part 3 to 8 – To be completed/authorized by a Medical Doctor

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

Name and Address of Insurer: SGEU Long Term Disability Plan 1011 Devonshire Dr N Regina SK S4X 2X4	**Name of the Plan's Medical Adjudicator:** Saskatchewan Blue Cross
Member's Last Name First Initial	**Member's Mailing Address:**
Member's DOB (mm/dd/yy)	**Member's S.I.N.**
In respect to this form, I hereby authorize the release of any information to the Insurer and the Plan's Medical Adjudicator. **Member's Signature** **Date (mm/dd/yy)**	

Part 3 – History and Findings: *Part 3 to 8 to be completed/authorized by a **Medical Doctor.***

To provide further information on any physical or psychological Illness/Injury, complete the applicable portions of this form and attach any applicable documents (such as x-ray, scans, consult reports, etc.).

3.1 Mechanism of injury or onset of illness	
3.2 To the best of my knowledge, the illness/injury started or happened on (mm/dd/yy).	**3.3 To the best of my knowledge, the Patient has been unable to work as a result of the disability from (mm/dd/yy).**
3.4 Date of first examination for the present condition (mm/dd/yy).	3.5 Dates of hospitalization (mm/dd/yy) From To Name of hospital

Part 4 – Diagnosis

4.1 Diagnosis of Physical Illness/Injury:
4.2 Physical Clinical Findings:
4.3 Diagnosis of Psychological Illness/Injury:

4.4 Psychological Clinical Findings:

4.5 Diagnostic tests ordered and findings (Attach copies of all results):

4.6 Is the condition as a result of a **workplace** issue: ☐ Yes ☐ No

If yes, describe the workplace incident and any other contributing factors (alleged harassment/conflict, workload or performance issues).

Part 5 – Complicating Factors

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

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

Please describe:

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

Part 6 – Treatment Plan

☐ No active treatment is required.

6.1 Current Treatment: (specify in each case):

6.2 List all Medications (dosage/frequency/start date):

List previous medications trialed and general response:

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

6.3 Referred for assessment / treatment to (specify name and appointment dates):

☐ Medical/Surgical Specialist _____

☐ Psychiatrist _____

☐ Psychologist _____

☐ Counsellor (social worker/mental health worker) _____

☐ Physical Therapist _____

☐ Chiropractor _____

☐ Other Referral _____ _____

☐ Education/Other Treatment _____

6.4 Has the Patient been fully compliant with the prescribed treatment plan? ☐ Yes ☐ No (If no, explain)

Part 7 – Return to Work - Restrictions / Limitations

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

7.2 Is the Patient fit to return to modified / alternate duties? ☐ Yes ☐ No (If yes, on _____ mm/dd/yy)

If 'Yes' in questions 7.2 above, does the Patient have:

☐ Physical Restrictions / Limitations (Fill in the Physical Restrictions / Limitations Section below)

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

If 'No' in question 7.2 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.

Physical Restrictions / Limitations

		Hours at one time					Total hours during 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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drive	☐ No Restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Reaching / Repetitive Movements ☐No Restriction	Left Arm ☐ below waist ☐ waist level ☐ chest level Right Arm ☐ 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

Cognitive / Psychological Restrictions / Limitations

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.**

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:

Part 8 – Attending Physician (NOTE: Physician's Stamp Must Be Affixed Below.)

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

Attending Physician - Please ensure *Practitioner Number* is entered and the form is **signed and dated**.

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

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