Desjardins Insurance
LIFE • HEALTH • RETIREMENT

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Physical Illnesses

Note: For psychological illnesses, complete the form on the reverse

Original request

The insured must complete this section

❶ Family name: _____ ❷ Given name: _____

❸ Contract no.: _____ Group or policy no. _____ Certificate no.

❹ Date of birth: Y Y Y Y M M D D

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____

1.2 Secondary: _____

1.3 Complications: _____

1.4 For the illnesses or associated symptoms diagnosed, has the patient previously:

a) received medical treatments ☐ b) consulted another physician ☐ c) taken drugs ☐ d) been hospitalized ☐ e) undergone examinations ☐

Specify the periods: _____

1.5 Is the disability related to: an accident ☐ an illness ☐ an occupational accident ☐ an automobile accident ☐

Date of the event: Y Y Y Y M M D D

a pregnancy No ☐ Yes ☐

a preventive withdrawal from work No ☐ Yes ☐ Scheduled date of delivery: Y Y Y Y M M D D

1.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability Y Y Y Y M M D D Currently

2. Treatment

2.1 Drugs – name – dosage: _____

2.2 Has the patient undergone or will undergo:

a) examinations or tests No ☐ Yes ☐ Specify: _____

b) surgery No ☐ Yes ☐ Day surgery ☐ Type: _____

Surgical procedure: _____ Date: Y Y Y Y M M D D

c) other treatments No ☐ Yes ☐ Specify: _____

d) hospitalization: from _____ to _____ Name of hospital: _____

e) a short stay under observation No ☐ Yes ☐ Number of hours: _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Dates of other consultations: _____ Follow-up frequency: _____

3.3 Referral to another physician: No ☐ Yes ☐ Name of physician: _____

Specialty: _____

3.4 Approximate duration of disability: No. of days _____ No. of weeks _____ Unspecified ☐ or date of return to work Y Y Y Y M M D D

3.5 How long before the patient will be able to return to work? No. of days _____ No. of weeks _____

part-time ☐ full-time ☐ gradual return ☐ Specify: _____

4. Questions specific to the contract

4.1 During the last five years, has the patient consulted or been treated by a physician or another practitioner, or taken drugs prescribed by a physician for one of the following illnesses or conditions: cancer or tumor, diabetes, hypertension, Crohn's disease, ulcerative colitis, hepatitis, heart diseases or blood vessel disorders, drug addiction or alcoholism, nervous or mental disorders, pulmonary disorders, renal or urinary problems, cerebral or neurological problems, disorders related to the spine, illnesses related to AIDS? Has the patient undergone an analysis showing the presence of HIV antibodies?

No ☐ Yes ☐ **If yes**, please indicate the following information:

Illnesses	Dates	Results	Periods of hospitalization	When was the patient informed of this illness?

4.2 _____

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: Area code + number

5.2 License number: _____ Fax: Area code + number

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: Y Y Y Y M M D D

NOTE: THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM