Equitable Life of Canada®

Head Office
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7
TF 1.800.265.4556 **T** 519.886.5210 **Fax** 1.888.505.4373
Email group-disability-claims@equitable.ca

DISABILITY BENEFITS ATTENDING PHYSICIAN'S STATEMENT PSYCHIATRIC

To allow us to make an assessment of your patient's claim, please answer all of the questions in full.

Instructions:
1. Please PRINT.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

Part 1: Patient Authorization

Policy Number: | Certificate Number: | Claim Number:

Name | Date of Birth: DD / MM / YYYY

Address (number, street, city, province and postal code)

Phone Number (include area code)

I hereby authorize the release to Equitable Life of Canada® any information requested by Equitable Life of Canada in respect of this claim.

Patient's Signature | Date: DD / MM / YYYY

Part 2: Attending Physician's Statement

1. Diagnosis (please use DSM IV Criteria)	Supporting Data Please describe the symptoms (severity and frequency) that support each axis of your diagnosis
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V Current GAF Score	
Highest GAF Score in This Year	
Lowest GAF Score in Past Year	

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2. History (please provide copies of all relevant clinical notes and consultation reports on file.)

When did symptoms start?	DD / MM / YYYY
When did symptoms worsen?	DD / MM / YYYY
Date patient stopped working due to this condition:	DD / MM / YYYY
Date of first visit for treatment or consultation	DD / MM / YYYY
Date of most recent visit:	DD / MM / YYYY

Frequency of visits: ❑ Weekly ❑ Monthly ❑ Other (specify)

Has patient ever had the same or a similar condition? ❑ Yes ❑ No ❑ Unknown

If yes, state when and describe:

Were work problems a factor in the development of your patient's condition? ❑ Yes ❑ No

If yes, please specify.

Have you completed WCB/WSIB forms? ❑ Yes ❑ No

Are patient's symptoms related to drug or alcohol abuse? ❑ Yes ❑ No

If yes, is patient enrolled in a substance abuse program? ❑ Yes ❑ No

If yes, state facility:

Has your patient ever been enrolled in a substance abuse program? ❑ Yes ❑ No If yes, state when:

Treatment

Treatment Dates	For What Condition?	Treatment Provider or Facility (name, address, clinical specialty)

Date of hospital in-patient admission:	DD / MM / YYYY
Date of discharge:	DD / MM / YYYY
Date of hospital out-patient admission:	DD / MM / YYYY

Name of hospital:

3. Precipitating and complicating factors
Please describe all factors that may have contributed to the onset of the condition(s) or may complicate their resolution.

❑ Workplace issues ❑ Social/Family Issues ❑ Physical/Mental Condition ❑ Financial/Legal Problems
❑ Coping Skills ❑ Alcohol/Drug Abuse ❑ Personality/Motivation
❑ Other Issues (describe)

Comments:

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4. Current treatment

Type of therapy: | Therapy goal:

Frequency and length of therapy/counselling sessions:

Number of therapy/counselling sessions to date:

Treatment compliance: | Treatment response to date:

	Medication:	Medication:	Medication:	Medication:	Medication:	Medication:
Date Started (d/m/y)						
Initial Dosage						
Initial Response						
Date of Last Dosage Change (d/m/y)						
Current Dosage						
Response						
Side Effects						
Compliance						
Date Medication Discontinued (d/m/y)						

Future Treatment Plans

What changes in your treatment plan are underway or are being considered?

5. Progress:

6. Return to work plans:

Prognosis for return to work:

Expected date patient will return to their regular occupation: DD / MM / YYYY

If your patient is unable to return to their regular occupation at this time, please specify when and under what circumstances they could return to work to their regular occupation or another occupation.

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7. Rehabilitation

Is your patient a suitable candidate for vocational rehab? ❑ Yes ❑ No
If yes, please specify. If no, why not?

If unable to return to work when and under what circumstances could patient return to other work?
(eg. modified duties, gradual return to work)

8. Competency

Do you believe your patient is competent to cash cheques and use the proceeds? ❑ Yes ❑ No
If no, why not?

Have you referred the case to the Public Trustee? ❑ Yes ❑ No

Are there any other comments you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

9. Have you completed other requests regarding your patient's current medical condition to other sources, i.e.

other insurance providers, Canada Pension Plan, WSIB/WCB, etc.? ❑ Yes ❑ No
If so, please provide details:

Name of Physician (please print)

Specialty:

Telephone: Fax:

Address (number, street, city, province & postal code):

Physician's signature Date:

Please keep a copy of this form for your records. **Please do not use staples.** Send this completed form, along with any other pertinent documentation, to:

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Alternatively, you can **scan** and **email** the forms to group-disability-claims@equitable.ca.
Or **fax** your documents to 519 883 7406 or fax toll free to 1 888 505 4373

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