

1 Family name: _____ **2** Given name: _____
3 Contract no.: **Q057** **4** Certificate number: _____
CONCORDIA UNIVERSITY **5** 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 Objective elements of the physical examination and investigation (**attach copy** of recent results, X-rays, ECG, or other tests or examinations):

 Weight: _____ lb kg Height: _____ ft/in m/cm Most recent blood pressure: _____
 1.4 Degree of the symptom's severity (M = mild, Md = moderate, S = severe)

	M Md S		M Md S
_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

2. Treatment

2.1 Drugs – name – dosage: _____
 2.2 Additional treatments (specify the type and frequency): _____
 2.3 Surgery (date, nature and procedure): _____
 2.4 Hospitalization: from _____ to _____ Name of hospital: _____
 2.5 Consultation with a specialist: No Yes **► Attach copy**

3. Follow-up and prognosis

3.1 Date of last consultation: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D
 3.2 Tests and examinations to come: _____
 3.3 Frequency of follow-up: _____
 3.4 Referral to a specialist: No Yes Name of physician: _____
Y Y Y Y M M D D
 3.5 Scheduled date of consultation with a specialist: Y Y Y Y M M D D Specialty: _____
 3.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability	Currently
_____	_____

 3.7 Evolution: progressive stable regressive
 3.8 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

 3.9 Patient's cooperation in the treatment: excellent average poor
 3.10 Would the patient benefit from assistance within the scope of a return to work? No Yes
 3.11 Approximate duration of the disability: No. of days _____ No. of weeks _____ Unspecified or date of return to work Y Y Y Y M M D D
 3.12 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

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: (_____)
 5.2 License number: _____ Fax: (_____)
 General practitioner Specialist Specify: _____
Y Y Y Y M M D D
 Signature: _____ Date: _____

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

1. Diagnosis

1.1 Principal: _____
 1.2 Secondary: _____
 1.3 Please describe the signs and symptoms and indicate the frequency and their individual degree of severity (M = mild, Md = moderate, S = severe)

Signs	M	Md	S	Symptoms	M	Md	S
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Treatment

2.1 Drugs – name – dosage: _____

2.2 **Is the patient consulting:** Since when? **Is the patient treated in:** Specify:

a psychiatrist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	a treatment centre	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
a psychologist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	a CLSC	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
a social worker	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	a day hospital	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
an other caregiver	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____	group therapy	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
				individual therapy	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____

AXE II) Associated personality disorders: No Yes Specify: _____
 Associated drug addiction, alcoholism or gambling problems: No Yes Specify: _____

AXE III) Associated illness: – diagnosis: _____
 – drugs prescribed: _____

AXE IV) Associated psychosocial stress factors (in the last 12 months):

<input type="checkbox"/> personal or interpersonal problems	<input type="checkbox"/> loss of employment or layoff	<input type="checkbox"/> professional problems
<input type="checkbox"/> marital/family life	<input type="checkbox"/> alcohol or drug abuse or gambling problems	
<input type="checkbox"/> other problems, specify: _____		

AXE V) General scale of functioning (according to the EGF scale of the DSM IV (0 to 100) 100 = perfect condition)
 – at the beginning of treatment _____ – currently _____

3. Follow-up and prognosis

3.1 Date of last consultation: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Follow-up frequency: _____

3.3 Will the patient be referred to a psychiatrist? No Yes Name of physician: _____

3.4 Patient's cooperation in the treatment: excellent average poor

3.5 If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

3.6 Would your patient benefit from assistance within the scope of a return to work? No Yes

3.7 Do you consider that the patient's condition has improved in an optimal way? No Yes

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

3.9 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

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: (_____) _____

5.2 License number: _____ Fax: (_____) _____

General practitioner Specialist Specify: _____

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