Desjardins Financial Security®

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.: Q057

CONCORDIA UNIVERSITY

❹ Certificate number:

❺ 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. Additional information

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

PRINT NEW REQUEST

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

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

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Psychological Illnesses

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

Original request

The insured must complete this section

❶ Family name: ❷ Given name:

❸ Contract no.: Q057 ❹ Certificate number:

CONCORDIA UNIVERSITY ❺ 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 Current symptoms:

1.4 Degree of severity of all symptoms: Mild ☐ Moderate ☐ Severe ☐ With psychotic elements ☐

1.5 Does the interruption of work result from problems related to:

☐ marital/family life ☐ loss of employment or layoff ☐ professional problems

☐ personal or interpersonal problems ☐ alcohol or drug abuse or gambling problems

☐ other problems, specify:

1.6 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 dates of previous episodes:

2. Treatment

2.1 Drugs – name – dosage:

2.2 Is the patient consulting: a psychiatrist No ☐ Yes ☐ a social worker No ☐ Yes ☐

a psychologist No ☐ Yes ☐ another health care provider No ☐ Yes ☐

If Yes, name of the caregiver consulted:

2.3 Hospitalization: from to Name of hospital:

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:

3.3 Follow-up frequency:

3.4 Will the patient be referred to a psychiatrist? No ☐ Yes ☐ Name of physician:

3.5 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

3.6 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:

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5.1 Family name, given name: Telephone: ( )

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General practitioner ☐ Specialist ☐ Specify:

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

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