HUMANIA ASSURANCE MD®

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Physical illnesses
Additional report

Part 1 - Insured Identification

The Insured must complete this section

Last name:

First name:

Contract N°: Certificat N°:

Social insurance N°: Date of birth: year / month / day

Part 2 - Declaration of the attending physician

Complete in block letters and give to the patient

Principal diagnosis:

Secondary diagnosis:

Objective elements of the physical examination and investigation (**attach copy** of recent result, X-rays, ECG, or other tests or examinations):

Weight: ☐ lb ☐ kg Height: ☐ ft/in ☐ m/cm Most recent blood pressure:

Degree of the symptom's severity (M = mild, Md = moderate, S = severe)

☐ M ☐ Md ☐ S ☐ M ☐ Md ☐ S

☐ M ☐ Md ☐ S ☐ M ☐ Md ☐ S

Treatment

Drugs (name, dosage):

Additional treatments (specify the type and frequency):

Surgery (date, nature and procedure):

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Treatment (...continued)

Hospitalization: from ____________ to ____________ Name of hospital: ____________

Consultation with a specialist: ☐ Yes ☐ No **Attach copy**

Medical follow-up and prognosis

Date of last consultation: year / month / day Next consultation: year / month / day

Tests and examinations to come: ____________

Frequency of follow-up: ____________

Referral to a specialist: ☐ Yes ☐ No Name of physician: ____________

Scheduled date of consultation with a specialist: year / month / day Speciality: ____________

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

At the beginnig of disability	Currently

Evolution : ☐ progressive ☐ stable ☐ regressive

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

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

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

Approximate duration of the disability: No. of days ____________ No. of weeks ____________

Unspecified ☐ or date of return to work: year / month / day

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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Questions specific to the contract

Part 3 - Identification of the physician

Family name, given name:

Telephone: Fax:

License number:

General practitioner ☐ Specialist ☐ Specify:

Signature: Date:

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

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