Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Attending Physician Statement (APS)
Short Term Disability Statement

Send to:
Email: luene@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

There are two parts to this form: the first part (Claimant Information and Authorization) is to be completed by you. The second part (Physician Questionnaire) is for your physician to complete and send back to Health Risk Services Inc. It is your responsibility to provide medical information to support your application for benefits and to pay any costs incurred in obtaining this information. In order to prevent processing delays, this form must be completed in its entirety by the employee and the attending physician, and returned to us within 10 business days from the first day of absence. For additional information, please contact us.

Claimant Information and Authorization to Release Information - Claimant to complete

Last Name:	First Name:	Date of Birth: (mm/dd/yyyy)	
Home Address:	City:	Province:	Postal Code:
Home Phone:	First Day of Absence: (mm/dd/yyyy)	Personal Health Care #:	
Employer Name:	Name of Manager:	Manager's Phone#:	

Please describe the reason for application:

I AUTHORIZE any physician, health practitioner, clinic or hospital or other medical organizations or any provincial motor vehicle board, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Health Risk Services Inc. having relevant information available as to my diagnosis, treatment and prognosis with regard to any physical or mental condition and/or treatment or tests completed on me, to provide to Health Risk Services Inc. and its duly authorized agents or representatives any and all such information to evaluate my application for benefits under the Short Term Disability Plan.

I hereby authorize Health Risk Services Inc., or such designated agent or successor as may be appointed and their respective authorized agents, including their legal representatives and investigators, to obtain, collect, receive, retain, examine, copy and disclose any personal information or personal health information, including consultation reports from or to any physician (including my treating physician) and/or any other medical practitioner, hospital, clinic, legal counsel, investigative agency, the Long Term Income Protection Plan Administrator and insurance company.

The purpose for which this information is collected and for which it may be disclosed is i) to adjudicate and manage my claim, ii) facilitate rehabilitation and return to work, iii) in the context of litigation or legal claims or the assessment thereof, iv) management of the employment relationship, and v) for the policy holder's statistical purposes.

I ACKNOWLEDGE that Health Risk Services Inc. reserves the right to undertake an independent medical examination or consultation with my attending physician(s) for the purpose of determining my eligibility for payment of Short Term Disability benefits and provide a copy of any independent medical examination report to my treating physician(s).

I AGREE that any information provided to Health Risk Services Inc. may be used by them for the assessment of my claim, and for any other purpose relating to the administration of my Short Term Disability benefits, including, but not limited to, use in assisting in my reintegration into the workplace. Only information related to work restrictions or fitness to work will be released to my Employer.

Signature of Claimant:	**Date Signed: (mm/dd/yyyy)**

Physician Questionnaire - Attending Physician to complete

This employee is applying for Short Term Disability benefits. This is not a request for examination, but for information taken from your chart. In order to prevent processing delays, this form must be completed by attending physician and returned to Health Risk Services Inc. within 10 business days from the first day of absence.

Claimant's Name:	Claimant's Date of Birth (mm/dd/yyyy):
Diagnosis:	
Primary diagnosis:	Secondary:
Severity: ◯ mild ◯ moderate ◯ severe	Severity: ◯ mild ◯ moderate ◯ severe
Date patient first consulted for this disability (mm/dd/yyyy):	

Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings) and medical history relevant to current medical condition causing absence from work. **Please include a copy of radiological tests, clinical notes, tests & any specialist reports.**

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Physician Questionnaire - Attending Physician to complete (continue)

If psychiatric disorder, complete the current axial diagnosis and the functional "GAF score".

AXIS I: _____
AXIS II: _____
AXIS III: _____
AXIS IV: _____

AXIS I: AXIS V (GAF SCORE)
AXIS II: Current GAF Score: _____
AXIS III: Highest GAF Score in the past Year: _____
AXIS IV: Lowest GAF Score in the past Year: _____

What are the patient's subjective symptoms? How have symptoms evolved to date?

Is the patient's condition pregnancy-related? ◯ Yes ◯ No If "Yes", EDD (mm/dd/yyyy)

Has the patient ever had the same or a similar condition? ◯ Yes ◯ No (If "Yes", please specify diagnosis and dates of treatment mm/dd/yyyy):

Is this condition due to injury or illness arising out of the patient's employment? ◯ Yes ◯ No

If "yes", has your office filed a claim for this patient's condition with the Workers' Compensation Board? ◯ Yes ◯ No

Was hospitalization and/or surgery required? ◯ Yes ◯ No (If "Yes", describe the details (dates mm/dd/yyyy, procedures, etc)):

Specific tests. If tests are prescribed, please provide test and scheduled dates (mm/dd/yyyy):

Treatment:

Since first being consulted on the patient's condition, please describe their current medical status:

◯ Worsened ◯ No change ◯ Improved ◯ Recovered

Please indicate **ALL** dates of visits for the current condition:

Month	Yr	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Date of next appointment: (mm/dd/yyyy)

Please list other Physicians who have been/will be involved in assessing the medical conditions.

Name	Specialty	Date seen or to be seen (mm/dd/yyyy)	Telephone

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Physician Questionnaire - Attending Physician to complete (continue)

Recommended or prescribed treatments, including therapies or medication, dosage and response (use additional pages, if necessary).

Medication	Dosage/frequency	Start Date (mm/dd/yyyy)	Duration	Response (good, moderate, poor)

☐ Chiropractor, start date (mm/dd/yyyy): ☐ Acupuncture, start date (mm/dd/yyyy): ☐ Physiotherapy, start date (mm/dd/yyyy):

☐ Massage Therapy, start date (mm/dd/yyyy): ☐ Counseling (Please note provider's specialty, with start date) (mm/dd/yyyy):

☐ Other treatment (Please describe, with start date) (mm/dd/yyyy):

Additional comments regarding treatment:

Please provide current physical limitations and restrictions, and specify if these prevent the employee from performing the normal duties of his/her job. Please note that modified work is available at the claimant's place of employment that will accommodate most common restrictions and limitations.

Functional Capacities:

a) Please specify if the individual is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

b) Is this illness/Injury preventing your patient from performing his/her pre-disability work? ◯ Yes ◯ No

c) If "Yes", does your patient require any of the following limitations?

	Yes	Limitation	No
Sitting	☐		☐
Standing Limitation	☐		☐
Walking Limitation	☐		☐
Limited repetitive use of upper limbs	☐		☐
Other	☐		☐

d) Please describe present work capability: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

e) Can modified work be performed? ◯ Yes ◯ No (If "Yes", Please describe duties below).

Return to work date (mm/dd/yyyy): ◯ Usual duties ◯ Modified duties/hours

In the case of a progressive return to work, please specify the work schedule.

Additional comments regarding work capabilities:

Information about the Attending Physician

Physician's Full Name (*Please Print Clearly*):

Address:	**City:**	**Province:**	**Postal Code:**
Phone: / **Fax:**	**Specialty:**		**License Number:**
Signature:	**Date: (mm/dd/yyyy)**		

Returning Mailing Address: #50, 12221 - 44 Street SE Calgary AB T2Z 4H3 | Email: luene@healthrisk.ca | Confidential Fax: 403-236-9420