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From anywhere... to anyone

Attending Physician's Statement

Short-Term Disability Claim

Please complete this form as soon as possible to expedite the processing of your patient's claim for disability benefits under the Canada Post Short-Term Disability Program. It should be completed and returned within 14 days from the onset of the disability to avoid interruptions of payment to the employee. The completed form should be mailed or faxed directly to:

MANULIFE FINANCIAL
2 QUEEN ST
PO BOX 4606 STN A
TORONTO ON M5W 4Z2
Telephone: 1-866-232-9674 or 613 369-2000
Fax: 1-866-232-9642 or 613 233-8233

This form is not to be used for workplace injuries/illnesses.

SECTION A To be completed by patient (please print)

Employee Name (Last, First, Middle initial):		
Employee ID#	E-mail:	
Home Phone #	Alternate Phone #	
Address (number, street, city, province, postal code):		
Date of Birth (dd/mm/yyyy):	Bargaining Agent (if applicable):	Date form provided to Physician (dd/mm/yyyy):

I hereby authorize the release of information held in my file by the physician named below to Manulife Financial and its agents and service providers for the purpose of assessing my claim and administering the disability plan regarding this claim. This medical information includes, but is not limited to copies of consultation reports, clinical notes, test results and hospital records supporting this claim. **I understand that I am responsible for any costs related to the completion of this form.**

Employee's signature: Date (dd/mm/yyyy):

SECTION B To be completed by the attending physician (please print)

Diagnosis(es) or working diagnosis(es): If psychological, please provide DSM IV Axis 1 diagnosis and GAF score. GAF score (if applicable):	Primary Diagnosis: Secondary Diagnosis:	If childbirth: expected or actual delivery date (dd/mm/yyyy):

Is the diagnosed disability the result of: ☐ Non-Occupational illness? ☐ Non-Occupational accident?

Has the patient had a similar or related condition? ☐ **No** ☐ **Yes** If yes, state when and describe condition:

Is the condition considered to be chronic? ☐ **No** ☐ **Yes** If yes, what precipitated the absence from work?

Date of first visit (dd/mm/yyyy): Date of last visit (dd/mm/yyyy):	Date first unable to work due to present condition(s) (dd/mm/yyyy): Expected date of return to work (dd/mm/yyyy):
Admitted to hospital? ☐ **No** ☐ **Yes** Date Admitted (dd/mm/yyyy):	Name of Institution: Hospital department/ward admitted to: Date Discharged (dd/mm/yyyy):

Treatment (current medication, types of drug(s), dosage and duration, physiotherapy, other):

SECTION C Physician's Acknowledgement and Authorization (please print)

I acknowledge that the information in this statement will be kept in a health file with Manulife Financial and may be accessed by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Address (number, street, city, province, postal code):	Telephone number: Fax number:
Signature:	Date signed (dd/mm/yyyy):

NOTE TO PHYSICIAN: If the disability is anticipated to be resolved within two weeks of its onset, no further information is required. If not, please complete section D.

SECTION D Additional information for absences known/expected to exceed two weeks (please print)

Describe the employee's condition in terms of symptomology (severity and frequency), objective findings and impact on activities of daily living.

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other_____

Patient's Height:_____ Patient's Weight:_____

Is complete recovery expected? ☐ **No** ☐ **Yes,** anticipated period of recovery _____

Please describe any factors that may affect this patient's ability to return to work.

Please attach copies of all relevant test results/investigations and consultation reports (if test results are not attached, it will be assumed that tests were not performed). If a consultation report is not attached please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist: Specialty: Date of Visit:

Please list any complications and additional condition(s) impacting your patient's level of function or the expected recovery period.

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations.

Physical impairment

Does your patient have a physical impairment?

☐ **No** ☐ **Yes**

If yes, please complete this section.

Based on your assessment please describe your patient's current abilities in the following areas:

Lifting (max. weight/frequency)		Sitting (how long/frequency)	
Carrying (max. weight/distance)		Standing (how long/frequency)	
Pushing/Pulling (max. weight/frequency)		Walking (distance/frequency)	
Walking on uneven ground (distance/frequency)		Climbing (how long/frequency)	
Working at heights (distance/frequency)		Crawling (duration/frequency)	

Remarks:

Cognitive/Mental impairment

Does your patient have a cognitive/mental limitation?

☐ **No** ☐ **Yes**

If yes, please complete this section.

Indicate if patient currently has cognitive/mental restrictions in the following areas:

	None	Mild	Moderate	Severe
Concentration (e.g., attention, orientation)				
Analytical reasoning (e.g., judgment)				
Learning new material (e.g., memory)				
Comprehension				
Social interaction (e.g., mood)				
Ability to multi-task				

In your opinion, is your patient competent to manage his/her own affairs? ☐ **No** ☐ **Yes**

Remarks:

Rehabilitation / Work re-entry

Has your patient expressed a desire to return to work? ☐ **No** ☐ **Yes**

Expected date of return to work to full duties (dd/mm/yyyy):

Please provide details about return-to-work plans for the patient:

To your knowledge is the patient following the recommended treatment program? ☐ **No** ☐ **Yes**

Has your patient's professional license certification, driver's or other license been restricted, suspended or revoked? ☐ **No** ☐ **Yes**

Physician Signature:

Date signed (dd/mm/yyyy):