Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3875 succ. Lévis
Lévis (Québec) G6V 0A7
Fax: 418-835-0194
1-844-409-6575

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Physical Illnesses

Original request

Note: For psychological illnesses, complete the form on the reverse. **The insured must complete this section.**

Last name and first name of the insured

Policy or group or contract no.	Certificate or identification no.	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

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

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Psychological Illnesses

Original request

Note: For physical illnesses, complete the form on the reverse. **The insured must complete this section.**

Last name and first name of the insured

Policy or group or contract no.	Certificate or identification no.	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:

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

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