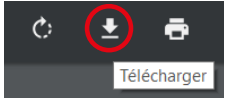
Steps to complete the form

1 Click on the download button for save the form on your computer.



2 Fill in the fields of the form and save your information before submitting it to us.

UV INSURANCE
P.O. Box 696, Drummondville, Quebec J2B 6W9
TEL.: 1 877 567-0988 FAX: (819) 474-1990

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Physical illnesses

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

Additional report

The insured must complete this section

❶ Family name: _____ ❷ Given name: _____

❸ Contract no.: _____ (Group or Contract no.) _____ (Certificat no.)

❹ Social insurance 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 Objective elements of the physical examination and investigation (**attach copy** of recent results, X-rays, ECG, or other tests or examinations)

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

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

	M	Md	S		M	Md	S
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

2. Treatment

2.1 Drugs - name- dosage _____

2.2 Additional treatments (specify the type and frequency): _____

2.3 Surgery (date, nature and procedure): _____

2.4 Hospitalization: from _____ to _____ Name of hospital: _____

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

3. Medical follow-up and prognosis

3.1 Date of last consultation: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Tests and examinations to come: _____

3.3 Frequency of follow-up: _____

3.4 Referral to a specialist: No ☐ Yes ☐ Name of physician: _____

3.5 Scheduled date of consultation with a specialist: Y Y Y Y M M D D Specialty: _____

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

At the beginning of disability	Currently

3.7 Evolution: progressive ☐ stable ☐ regressive ☐

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

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

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

3.11 Approximate duration of the disability: No. of days ____ No. of weeks ____ Unspecified ☐ or date of return to work Y Y Y Y M M D D

3.12 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. Questions specific to the contract

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

574-A (11-12)

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

UV INSURANCE
142, HÉRIOT, P.O. BOX 696 DRUMMONDVILLE (QUEBEC) J2B 6W9
TEL.: 1 877 567-0988 FAX: (819) 474-1990

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Psychological illnesses

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

Additional report

The insured must complete this section

❶ Family name: _____ ❷ Given name: _____

❸ Contract no.: _____ (Group or Contract no.) _____ (Certificat no.)

❹ Social insurance 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 Please describe the signs and symptoms and indicate the frequency and their individual degree of severity (M=mild, Md=moderate, S=severe)

Signs	M	Md	S	Symptoms	M	Md	S
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

2. Treatment

2.1 Drugs - name- dosage _____

2.2

Is the patient consulting a:			Since when	Is the patient treated:			Specify:
psychiatrist	No ☐	Yes ☐		in a treatment centre	No ☐	Yes ☐	
psychologist	No ☐	Yes ☐		in a CLSC	No ☐	Yes ☐	
social worker	No ☐	Yes ☐		in a day therapy	No ☐	Yes ☐	
other caregiver	No ☐	Yes ☐		in group therapy	No ☐	Yes ☐	
				in individual therapy	No ☐	Yes ☐	

AXE II) Associated personality disorders? No ☐ Yes ☐ Specify: _____

Associated drug addiction, alcoholism or gambling problems? No ☐ Yes ☐ Specify: _____

AXE III) Associated illness: — diagnosis: _____

— drugs prescribed: _____

AXE IV) Associated psychosocial stress factors (in the last 12 months):

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

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

☐ other problems, specify: _____

AXE V) General scale of functioning (according to the EGF scale of the DSM IV (0 to 100) 100=perfect condition)

— at the beginning of treatment: _____ — currently: _____

3. Follow-up and prognosis

3.1 Date of last consultation: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Follow-up frequency: _____

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

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

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

_____

_____

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

3.7 Do you consider that the patient's condition has improved in an optimal way? No ☐ Yes ☐

3.8 Approximate duration of the disability: No. of days ____ No. of weeks ____ Unspecified ☐ or date of return to work Y Y Y Y M M D D

3.9 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. Questions specific to the contract

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

574-A (11-12)

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