canada life

Psychiatric Form

MORNEAU SHEPELL

Attending Physician's Statement

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL**

INSTRUCTIONS

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. **Any charge for completion of this form is the patient's responsibility.**

Claims Administrator: The Canada Life Assurance Company (Canada Life)/Morneau Shepell PLAN NO.

Part 1: Patient Information

Name *(please print)* | Date of birth *(day, month, year)*

Address *(number, street, city, province, postal code)* | Telephone no. *(including area code)* ( ) –

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Canada Life/ Morneau Shepell for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Canada Life/ Morneau Shepell and administering the group benefits plan. Medical and health information excludes genetic test results.

I acknowledge that the personal information is needed by Canada Life/ Morneau Shepell for the purposes stated above. I acknowledge that my consent enables Canada Life/ Morneau Shepell to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Plan Member/Employee Signature | Date of Consent (dd/mm/yyyy)

Part 2: Attending Physician's Statement

1 DIAGNOSIS (PLEASE USE DSM IV CRITERIA)

Axis I

Axis II

Axis III

Axis IV 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐

Axis V Current GAF (Global Assessment of Functioning) Score

Highest GAF Score in Past Year

Lowest GAF Score in Past Year

SUPPORTING DATA

Please describe the symptoms (including severity and frequency), and any medical or psychological test results that support each axis of your diagnosis.

2 HISTORY (Please provide copies of all relevant clinical notes and consultation reports.)

Date symptoms first appeared *(day, month, year)*

Date patient ceased to work because of impairment *(day, month, year)*

Date of first visit for treatment or consultation *(day, month, year)*

Has patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe:

Date of latest attendance: ____/____/____ (D/M/Y) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

Treatment for Psychiatric/Psychological Problems

Treatment Dates	For What Problem?	Treatment Provider or Facility *(name, address, clinical specialty)*

Date of hospital inpatient admission: ____/____/____ (D/M/Y) Date of discharge: ____/____/____ (D/M/Y)

3 PRECIPITATING AND COMPLICATING FACTORS

Please describe all factors that may have contributed to the onset of the clinical problem(s) or may complicate their resolution.

☐ Workplace Issues ☐ Social / Family Issues ☐ Physical / Medical Condition ☐ Financial / Legal Problems

☐ Coping Skills ☐ Alcohol / Drug Abuse ☐ Personality / Motivation ☐ Other Issues

Comments:

4 CURRENT TREATMENT, PSYCHOTHERAPY OR COUNSELLING

Therapy method and goal(s): _____

Frequency and length of therapy/counselling sessions: _____

Number of therapy/counselling sessions to date: _____

Treatment compliance: _____

Treatment response to date: _____

Expected outcomes and time-frame: _____

Medications

Medication Name				
Date Started (d/m/y)				
Initial Dosage				
Initial Response				
Date of Last Dosage Change (d/m/y)				
Current Dosage				
Response				
Side-Effects				
Serum Levels				
Compliance				
Date Medication Discontinued (d/m/y)				

Future Treatment Plans

What changes in your treatment plan are underway or are being considered? _____

5 PROGNOSIS

Prognosis for medical recovery: _____

Other factors affecting recovery: _____

Is there any restriction you would like to see placed on patient's return to work? (check appropriate box) ☐ Yes ☐ No

Comments: _____

Estimated duration of restriction: _____

What is being done (or is needed) in the following areas to help your patient return to work? (check appropriate box)

☐ Physical Reconditioning ☐ Stress Management or Coping Skills ☐ Social Confidence-Building ☐ Vocational Counselling ☐ Other Needs

Comments: _____

6 COMMENTS - Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

Name of attending physician *(please print)*	Specialty	Telephone no. *(including area code)*
		( ) –

Address *(number, street, city, province, postal code)*

Signature	Date *(day, month, year)*

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