AGA BENEFIT SOLUTIONS

# SUPPLEMENTARY DECLARATION OF ATTENDING PHYSICIAN

## Physical illnesses

**Note : for psychological illnesses, complete the form on the reverse**

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**Section to be filled out by patient**

Last name : ______ First name : ______ Date of birth : ______

Contract No. ______ Group/Division No. : ______ Certificate No. : ______

## ATTENDING PHYSICIAN'S DECLARATION (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. FOLLOW UP AND PROGNOSIS

3.1 Date of last consultation : ______ Next consultation : ______

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 : ______ Specialty : ______

3.6 Describe functional limitations that prevent the patient from carrying out professional duties of 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 : # days ______ # weeks ______ Unspecified ☐ or date of return to work ______

3.12 How long before the patient will be able to return to work ? # days ______ # weeks ______

part-time ☐ full-time ☐ gradual return ☐ Specify : ______

### 4. QUESTIONS SPECIFIC TO THE CONTRACT

______

### 5. IDENTIFICATION OF THE PHYSICIAN

5.1 Last/First name (block letters) ______ Telephone : ( )

5.2 License No. ______ Fax : ( )

General practitioner ☐ Specialist ☐ Specify : ______

5.3 Address : ______

Signature : ______ Date (Y / M / D) : ______

**NOTE : THE PATIENT MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM**