



## Attending Physician Statement (APS) Short Term Disability Application

Dear Claimant:

There are two parts to this form: the first part (Claimant Information and Authorization) is to be completed by you. The second part (Physician Questionnaire) is for your physician to complete and fax back to Unistar Special Risks Inc at 1.800.364.0754. **It is your responsibility to provide medical information to support your application for benefits and to pay any costs incurred in obtaining this information.** In order to prevent processing delays, this form must be completed by the employee and the attending physician, and returned to us within 10 business days from the first day of absence. For additional information, please contact us at 1.877.900.0250 (Confidential toll-free fax: 1.800.364.0754).

### Claimant Information and Authorization to Release Information - Claimant to complete

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Personal Health Care #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ First Day of Absence: \_\_\_\_\_

Employee Home Address: \_\_\_\_\_

Name of Manager: \_\_\_\_\_ Manager's Phone: \_\_\_\_\_

Please describe your reason for being absent from work: \_\_\_\_\_

I AUTHORIZE any physician, health practitioner, clinic or hospital or other medical organizations or any provincial motor vehicle board, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with Unistar Special Risks Inc. having relevant information available as to my diagnosis, treatment and prognosis with regard to any physical or mental condition and/or treatment or tests completed on me, to provide to Unistar Special Risks Inc. and its duly authorized agents or representatives any and all such information to evaluate my application for benefits under the Short Term Disability Plan.

I hereby authorize Unistar Special Risks Inc., or such designated agent or successor as may be appointed, Echelon General Insurance Company and their respective authorized agents, including their legal representatives and investigators, to obtain, collect, receive, retain, examine, copy and disclose any personal information or personal health information, including consultation reports from or to any physician (including my treating physician) and/or any other medical practitioner, hospital, clinic, legal counsel, investigative agency, the Long Term Income Protection Plan Administrator and insurance company.

The purpose for which this information is collected and for which it may be disclosed is i) to adjudicate and manage my claim, ii) facilitate rehabilitation and return to work, iii) in the context of litigation or legal claims or the assessment thereof, iv) management of the employment relationship, and v) for the policy holder's statistical purposes.

I ACKNOWLEDGE that Unistar Special Risks Inc. reserves the right to undertake an independent medical examination or consultation with my attending physician(s) for the purpose of determining my eligibility for payment of Short Term Disability benefits and provide a copy of any independent medical examination report to my treating physician(s).

I AGREE that any information provided to Unistar Special Risks Inc. may be used by them for the assessment of my claim, and for any other purpose relating to the administration of my Short Term Disability benefits, including, but not limited to, use in assisting in my re-integration into the workplace. Only information related to work restrictions or fitness to work will be released to my Employer.

Signature of Claimant: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Physician Questionnaire - Attending Physician to complete**

This employee is applying for Short Term Disability benefits. This is not a request for examination, but for information taken from your chart. **In order to prevent processing delays, this form must be completed by attending physician and returned to Unistar SRI within 10 business days from the first day of absence.**

**Diagnosis:**

Primary diagnosis: \_\_\_\_\_ Secondary: \_\_\_\_\_

Severity:  mild  moderate  severe      Severity:  mild  moderate  severe

Date patient first consulted for this disability: \_\_\_\_\_ Date symptoms first appeared: \_\_\_\_\_

Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings) and medical history relevant to current medical condition causing absence from work. **Please include a copy of radiological tests, clinical notes, tests & any specialist reports.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If psychiatric disorder, complete the current axial diagnosis and the functional "GAF score".

AXIS I: \_\_\_\_\_      AXIS V (GAF SCORE)  
AXIS II: \_\_\_\_\_      Current GAF Score: \_\_\_\_\_  
AXIS III: \_\_\_\_\_      Highest GAF Score in the past Year: \_\_\_\_\_  
AXIS IV: \_\_\_\_\_      Lowest GAF Score in the past Year: \_\_\_\_\_

What are the patient's subjective symptoms? How have symptoms evolved to date?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the patient's condition pregnancy-related?  Yes  No (If "Yes", EDD \_\_\_\_\_)

Has the patient ever had the same or a similar condition?  Yes  No  
(If "Yes", please specify diagnosis and dates of treatment): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is this condition due to injury or illness arising out of the patient's employment?  Yes  No

If "yes", has your office filed a claim for this patient's condition with the Workers' Compensation Board?  Yes  No

Was hospitalization and/or surgery required?  Yes  No (If "Yes", describe the details (dates, procedures, etc)):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific tests. If tests are prescribed, please provide test and scheduled dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Claimant's Name: \_\_\_\_\_ Claimant's Date of Birth (m/d/y): \_\_\_\_\_

**Treatment:**

Since first being consulted on the patient's condition, please describe their current medical status:

- Worsened       No change       Improved       Recovered

Please indicate ALL dates of visits for the current condition:

Month	Yr	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

Date of next appointment: \_\_\_\_\_

Please list other Physicians who have been/will be involved in assessing the medical conditions.

Name	Specialty	Date seen or to be seen	Telephone

Recommended or prescribed treatments, including therapies or medication, dosage and response (use additional pages, if necessary).

Medication	Dosage/frequency	Duration	Start Date (d/m/y)	Response (good, moderate, poor)

Chiropractor, start date: \_\_\_\_\_  Acupuncture, start date: \_\_\_\_\_

Physiotherapy, start date: \_\_\_\_\_  Massage Therapy, start date: \_\_\_\_\_

Counseling (Please note provider's specialty, with start date): \_\_\_\_\_

Other treatment (Please describe, with start date): \_\_\_\_\_

Additional comments regarding treatment:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Claimant's Name: \_\_\_\_\_ Claimant's Date of Birth (m/d/y): \_\_\_\_\_

Please provide current physical limitations and restrictions, and specify if these prevent the employee from performing the normal duties of his/her job. Please note that modified work is available at the claimant's place of employment that will accommodate most common restrictions and limitations.

**Functional Capacities:**

a) Please specify if the individual is:  Ambulatory  House Confined  Bed Confined  Hospital Confined

b) Is this illness/Injury preventing your patient from performing his/her pre-disability work?  Yes  No

c) If "Yes", does your patient require any of the following limitations?

	Yes	Limitation	No
Sitting	<input type="checkbox"/>	_____	<input type="checkbox"/>
Standing Limitation	<input type="checkbox"/>	_____	<input type="checkbox"/>
Walking Limitation	<input type="checkbox"/>	_____	<input type="checkbox"/>
Limited repetitive use of upper limbs	<input type="checkbox"/>	_____	<input type="checkbox"/>
Other	<input type="checkbox"/>	_____	<input type="checkbox"/>

d) Please describe present work capability:  Sedentary  Light  Medium  Heavy  Very Heavy

e) Can modified work be performed?  Yes  No (If "Yes", Please describe duties below).

**Prognosis:**

Anticipated return to work date: \_\_\_\_\_ (DD/MM/YY)  Usual duties  Modified duties/hours

In the case of a progressive return to work, please specify the work schedule.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional comments regarding work capabilities:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Information about the Attending Physician**

Physician's Name (**Please Print**): \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Specialty: \_\_\_\_\_ License Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mailing Address:**

Suite 850 -10655 Southport Rd. SW, Calgary, AB T2W 4Y1

CONFIDENTIAL FAX: 800.364.0754