OTIP
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OTIP RAEO®

Clear text

Attending Physician's Statement of Disability
Physical Health Conditions

The patient is responsible for all expenses related to the completion of this form. Please print neatly and retain a copy of this form for your records.

MEMBER INFORMATION - To be completed by the patient

Name (Last, First and Middle Initial)		
Address (Number, Street and Apt.)		
City	Province	Postal code
Home telephone number	Alternate telephone number	Employer/School board
Group plan number	Division number	Date of birth *(mm/dd/yyyy)*

AGREEMENT, ACKNOWLEDGMENT AND AUTHORIZATION OF PATIENT

I authorize any licensed physician, medical practitioner or health-care professional who has observed me for diagnosis or treatment, any hospital, clinic, or other medical facility where I have been a patient to release to the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP") any personal health information, including but not limited to, copies of consultation reports, clinical notes, test results, my medical history, treatment, independent medical assessments and hospital records, for the purposes of benefits plan administration, audit, and the assessment, investigation and management of my claim.

I authorize OTIP to collect, use and disclose information needed for the adjudication of my claim with any person or organization noted above who has relevant information pertaining to my claim.

I agree that this authorization is valid for the duration of my claim.

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

I understand that I am responsible for any fees related to the completion of this form.

Signature (Patient):_____ Date *(mm/dd/yyyy)*_____

ATTENDING PHYSICIAN INFORMATION – To be completed by the physician

Name (Last, First and Middle Initial)		
Address (Number, Street and Apt.)		
City	Province	Postal code
Office telephone number	Fax number	Specialty

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1. DIAGNOSIS

Primary: _____

_____

_____

Secondary and/or complications: _____

_____

_____

If childbirth - Expected or Actual delivery date *(mm/dd/yyyy)* _____

Is this condition due to:

Occupational illness/injury ☐ Yes ☐ No

If yes, date of event: *(mm/dd/yyyy)* _____

Auto accident ☐ Yes ☐ No

If yes, date of event: *(mm/dd/yyyy)* _____

Have you completed any other disability claim forms recently for this patient? ☐ Yes ☐ No

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Date of first visit to you pertaining to this condition:

*(mm/dd/yyyy)*_____

First date of work absence due to condition:

*(mm/dd/yyyy)*_____

2. TREATMENT

E.g. Special programs, therapies, medications: (including prescribed dosages):

_____

_____

_____

_____

Frequency of visit: ☐ Weekly ☐ Monthly ☐ Other (describe) _____

Date of last visit: *(mm/dd/yyyy)* _____

Has patient been treated for this same or similar condition in the past? ☐ Yes ☐ No

If yes, date: *(mm/dd/yyyy)*_____ Treatment provider: _____

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Please elaborate: _____

3. RESPONSE TO TREATMENT

Please describe the response to treatment to date: ☐ Recovered ☐ Improved ☐ No change ☐ Retrogressed

Are there any plans to change or augment the current treatment program? ☐ Yes ☐ No

If so, please explain: _____

4. HOSPITALIZATION

Is/was the patient hospitalized? ☐ Yes ☐ No Is future hospitalization planned? ☐ Yes ☐ No

	Date of admittance *(mm/dd/yyyy)*	Date of discharge *(mm/dd/yyyy)*	Institution name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(ies):

	Date *(mm/dd/yyyy)*	Description
1.		
2.		

5. INVESTIGATIONS

Please attach copies of all relevant documents from the date last worked to present:

- Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
- Consultation reports
- Clinic notes

Please note if the above has not been included, this will delay the processing of your patient's claim.

Are tests/investigations pending? ☐ Yes ☐ No

	Date *(mm/dd/yyyy)*	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future? ☐ Yes ☐ No

	Name of specialist	Specialty	Address	Date *(mm/dd/yyyy)*
1.				
2.				

6. CLINICAL FINDINGS AND OBSERVATIONS

Please describe the patient's symptoms including history, severity and frequency: _____

How have the patient's symptoms evolved to date? ☐ Improved ☐ No change ☐ Retrogressed

7. RESTRICTIONS AND LIMITATIONS

Based on your clinical findings and observations, please describe the patient's current restrictions and limitations: _____

Has any licence held by the patient been restricted or revoked as a result of this condition? ☐ Yes ☐ No

If yes, as of when? *(mm/dd/yyyy)* _____ Type of licence: _____

Do you have concerns about the patient's ability to manage his/her own affairs? ☐ Yes ☐ No

8. COMPLICATING FACTORS

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

☐ Workplace issues ☐ Social/Family issues ☐ Financial/Legal problems

☐ Physical condition ☐ Alcohol/Drug abuse ☐ Medication side effects

☐ Pain perception ☐ Coping skills ☐ Personality/Motivation ☐ Other

Please describe:

Please describe the supports in place, or planned, to assist with these issues:

9. RETURN-TO-WORK

What return-to-work goals have been discussed with the patient? Please explain:

AUTHORIZATION OF ATTENDING PHYSICIAN

I certify that the information in this form, and any further verbal or written statement provided by me in the future concerning this claim, is true and complete to the best of my knowledge. I understand that the information in this form will be kept in a benefits health file relating to this claim and might be accessible by third parties to whom authorized access has been granted. I acknowledge and agree that by signing this document I consent to the unedited disclosure of any information contained herein, to the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP").

Signature (Attending Physician): _____ Date *(mm/dd/yyyy)* _____