Attending Physician's Questionnaire Claim for Long-Term Disability Benefits *Mental Health Condition SunAdvantage*

Sun Life Financial

Please complete this form based on your patient's current medical condition. The information you provide will assist Sun Life Assurance Company of Canada (Sun Life) to understand your patient's condition, treatment, prognosis and potential for recovery. Thank you for your time and cooperation.

Please note that any reference to Attending Physician (doctor) also refers to Licensed Physician or Nurse Practitioner.

NOTE: There are three Questionnaires included in your patient's LTD package – Mental Health, Musculoskeletal and one for other conditions. Only one form needs to be completed. Please choose the form most appropriate for your patient's condition. Your patient is responsible for any cost associated with the completion of this form.

Clear

1 Plan member information and consent (to be completed by the patient)

First name	Last name	☐ Male ☐ Female
Address (street number and name)		Apartment or suite
City	Province	Postal code
Home telephone number	Alternate telephone number	
Email address		

Contract number	Member ID number	Height ft in. / m cm	Weight ☐ lbs. ☐ kg	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)

Please list your present medications

Name of medication	Dosage (mg)	How often?

Member's consent & signature

I authorize my doctor to collect, use and disclose my personal information to Sun Life, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this consent is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this consent or electronic version is as valid as the original. Please note that genetic testing information is not required, so please do not include.

Plan member signature	Date (dd-mm-yyyy)
X	

2 About the condition (to be completed by doctor)

Plan member's first name	Last name	Date of birth (dd-mm-yyyy)

I am the: ☐ Attending physician ☐ Consulting psychiatrist, Consulting psychologist ☐ Other (please specify) _____

Current diagnosis

Primary
Secondary

Has the diagnosis been communicated to your patient? ☐ Yes ☐ No

Is this condition related to:

☐ Occupational illness/injury ☐ Auto accident ☐ Criminal act If so, date of event: Date (dd-mm-yyyy)

Details

First date of work absence due to this condition (dd-mm-yyy)	Date of first visit to you pertaining to this condition (dd-mm-yyy)

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

Date (dd-mm-yyyy)	By whom

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

Symptoms

Please describe your patient's current symptoms, including frequency and severity.

Symptom	Frequency	Severity

How have your patient's symptoms evolved to date? ☐ Improved ☐ No change ☐ Worsened

3 Clinical findings and observations

Investigations

Please attach copies of all relevant:
- test results/investigations (If test results are not attached, we will interpret this as tests were not performed)
- consultation reports

Please note that genetic testing information is not required, so please do not include.

Are tests and/or investigations pending? ☐ No ☐ Yes If yes,

Date report expected (dd-mm-yyyy)	Description
Date report expected (dd-mm-yyyy)	Description
Date report expected (dd-mm-yyyy)	Description

If you are not the treating specialist, is your patient currently under the care of a specialist? ☐ No ☐ Yes

If yes, please attach copies of consultation reports. If consultation reports are not attached or not yet received, please provide the following:

Name of specialist	Specialty	Date of appointment (dd-mm-yyyy)
Name of specialist	Specialty	Date of appointment (dd-mm-yyyy)

Please describe how the condition is impacting the following and to what degree.

	No impact	Mild	Moderate	Severe
Appearance (Self Care)	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy/vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration/focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect/mood	☐	☐	☐	☐
Insight/judgement	☐	☐	☐	☐
Self-criticism	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Weight and/or Appetite	☐	☐	☐	☐

Observations or comments supporting how the condition is impacting your patient.

3 Clinical findings and observations (continued)

Complicating factors

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

☐ Workplace issues ☐ Social/family issues ☐ Financial/legal problems ☐ Self-harm behavior ☐ Physical condition
☐ Alcohol/drug use ☐ 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.

Has any licence held by your patient been restricted or revoked as a result of this condition? ☐ No ☐ Yes If yes, as of when?

Date (dd-mm-yyyy)	Type of licence

4 Treatment – Special programs, therapies, medications

How long has your patient been under your care? _____

Date of last visit (dd-mm-yyyy)	Date of next scheduled visit (dd-mm-yyyy)

Since the first visit, how often have you seen your patient? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

Has your patient been treated for this same or similar condition in the past? ☐ Yes ☐ No If yes, date. Date (dd-mm-yyyy)

Treatment provider

Medications prescribed by you (only those not identified by the member in section 1)

Medication	Dosage	Date started (dd-mm-yyyy)	Response/Comments

Medications prescribed by other physician(s)

Medication	Dosage	Date started (dd-mm-yyyy)	Response/Comments

4 Treatment – Special programs, therapies, medications (continued)

Treatment details – Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, day hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd-mm-yyyy)	Frequency of visits	Date of last visit (dd-mm-yyyy)	Response
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		

Treatment details – Concurrent Physical conditions (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd-mm-yyyy)	Frequency of visits	Date of last visit (dd-mm-yyyy)	Response
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		

Has your patient recently been hospitalized for their current condition? ☐ No ☐ Yes
If yes, please provide copies of the hospital discharge summary. If this is not available, please provide the following:

Date of any hospitalizations

Date admitted (dd-mm-yyyy)	Date discharged (dd-mm-yyyy)	Institution name

Overall response to treatment

Please describe the response to treatment to date: ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

Is your patient following the recommended treatment program? ☐ No ☐ Yes
If no, please explain.

Are there any plans to change or augment the current treatment program? ☐ No ☐ Yes
If yes, please explain.

5 Prognosis and recovery

Sun Life encourages rehabilitation assistance, modified work or light duties to return an employee to the workplace as soon as medically possible. Based on the information you have provided we will review your patient's rehabilitation potential.

What return-to-work goals have been discussed with your patient? Please explain.

Please provide your patient's prognosis for improvement.

Please provide any other information that will help us understand your patient's current condition, recovery goals and prognosis.

6 Attending physician's acknowledgement

The information in this statement will be kept in a disability file with the insurer or plan administrator and may be disclosed to the patient, third parties who have been authorized by the patient or Sun Life's agents and service providers having a right to access the information.

By providing this information, I consent to the unedited release of any information in this form. I understand that I must notify you in writing if there is a significant likelihood that such disclosure to either the patient or a third party authorized by the patient would adversely effect the health of the patient.

Last name of attending physician (please print)	First name	Certified specialist	Physician's stamp
Address (street number and name)			
City	Province	Postal code	
Telephone number	Fax number		
Physician's signature X			Date signed (dd-mm-yyyy)

Return this statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun life Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. Please retain the original copy for your records.

If you live in the Atlantic provinces, Quebec or Ottawa

Montreal:
Fax: 1-866-639-7846
PO Box 11037 Stn CV
Montreal QC H3C 4W8

For all other provinces or territories

Kitchener - Waterloo:
Fax: 1-866-209-7215
PO Box 100 Stn C
Kitchener ON N2G 3W9