Attending Physician's Questionnaire Claim for Disability Insurance *Musculoskeletal Conditions*

Policy no. 12500-G

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 Disability Insurance (DI) claim 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 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		

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

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 Specialist ☐ Other (please specify) _____

Current diagnosis

Primary
Secondary

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

Is this condition related to:

☐ Occupational illness/injury ☐ Auto accident ☐ Criminal act If so, date of event:

Date (dd-mm-yyyy)

Details

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

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

Date (dd-mm-yyyy)	By whom

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

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)

If no, have you referred or are you planning to refer your patient to a medical specialist? ☐ No ☐ Yes

If yes, please indicate: Referral date (dd-mm-yyyy) The anticipated wait time: _____

Please confirm your patient's Weight _____ Height _____

Is your patient in a weight reduction program? ☐ Yes ☐ No

Neurological findings

Weakness present: ☐ Yes ☐ No

Muscle wasting noted: ☐ Yes ☐ No

Decreased sensation or numbness present: ☐ Yes ☐ No

Reflexes: ☐ Normal ☐ Diminished ☐ Absent

Please describe the affected joint or muscle group.

3 Clinical findings and observations (continued)

Range of motion

List affected joint(s) and/or muscle group(s)
(Note: Specify findings if more than one joint is involved)

1. _____
2. _____
3. _____
4. _____

Please provide applicable ROM findings (in degrees), for each affected joint/muscle group as numbered to the left.

	1	2	3	4
Flexion				
Lateral flexion				
Extension				
Internal rotation				
External rotation				
Abduction				
Adduction				
Rotation				
Supination				
Pronation				
Grip strength				
Straight leg raising	Sitting Lt. / Rt.		Lying Lt. / Rt.	

Functional evaluation

Has any formal functional testing been done (e.g., functional abilities evaluation)? ☐ No ☐ Yes If yes, please attach a copy of the report.
Please indicate if your patient has reported or exhibited any difficulty, and if so, level of difficulty with the following:

	None	Slight	Moderate	Severe	Is this consistent with physical or cognitive findings? Please comment.
Cognition	☐	☐	☐	☐	
Sensation	☐	☐	☐	☐	
Dexterity	☐	☐	☐	☐	
Driving	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	
Standing	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Reaching above shoulder	☐	☐	☐	☐	
Reaching below shoulder	☐	☐	☐	☐	
Squatting	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	

Provide an estimated maximum that your patient can lift
☐ (0-10 lbs) ☐ (11-20 lbs) ☐ (21-30 lbs) ☐ (31-40 lbs) ☐ (41-50 lbs) ☐ (50 lbs +)

3 Clinical findings and observations (continued)

Please comment on any additional medical conditions or complications impacting your patient's level of function or the expected recovery period.

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 ☐ 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

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 _____

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 (continued)

Treatment details – Please provide details of the current treatment program (e.g. physiotherapy, pain management, chiropractic, psychotherapy, cognitive behavioural, massage, exercise, other rehabilitation therapy, etc)

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

Has surgery been performed or is it planned? ☐ No ☐ Yes If yes, indicate the type of surgery.

Surgery	
Date performed (dd-mm-yyyy)	Date planned (dd-mm-yyyy)

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 questionnaire will be kept in a disability file with Sun Life 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 Questionnaire and any other supportive documents to your patient or fax it to the confidential number that appears below. Alternatively, you can mail the documents directly to the Sun Life Assurance Company of Canada Montreal Group Disability Management Office. You do not need to mail information that you fax. Please retain the original copy for your records.

Montreal Group Disability Management Office
Federal Government Disability Insurance Plan
Sun Life Assurance Company of Canada
PO Box 12500 Station CV
Montreal, QC H3C 5T6
Fax: 1-866-639-7849