HUMANIA ASSURANCE MD®

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Psychological illnesses
Additional report

Part 1 - Insured Identification

The Insured must complete this section

Last name:

First name:

Contract Nº: Certificate Nº:

Date of birth: year / month / day

Part 2 - Declaration of the attending physician

Complete in block letters and give to the patient

Principal Diagnosis:

Secondary Diagnosis:

Please describe the signs and symptoms and indicate the frequency and their individual degree of severity (M = mild, Md = moderate, S = severe)

☐ M ☐ Md ☐ S ☐ M ☐ Md ☐ S

☐ M ☐ Md ☐ S ☐ M ☐ Md ☐ S

Treatment

Drugs (name, dosage):

Since when: Specify :

Is the patient consulting a:

Psychiatrist?	☐ Yes ☐ No	in a treatment centre	☐ Yes ☐ No
Psychologist?	☐ Yes ☐ No	in a CLSC	☐ Yes ☐ No
Social worker?	☐ Yes ☐ No	in a day therapy	☐ Yes ☐ No

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Treatment (...continued)

Other caregiver? ☐ Yes ☐ No

in a group therapy ☐ Yes ☐ No

in individual therapy ☐ Yes ☐ No

Axe II) Associated personality disorders? ☐ Yes ☐ No

Associated drug addiction, alcoholism or gambling problems? ☐ Yes ☐ No

Axe III) Associated illness: - diagnosis:

- drugs prescribed:

Axe IV) Associated psychosocial stress factors (in the last 12 months):

☐ marital/family life ☐ loss of employment of layoff ☐ Professional problems

☐ Personal or interpersonal problems ☐ alcohol or drug abuse and/or gambling problems

other problems, specify:

Axe V) General scale of functioning (according to the EGF scale of the DSM IV (0 to 100) 100 = perfect condition)

at the beginning of treatment: currently:

Follow-up and prognosis

Date of last consultation: year / month / day Next consultation: year / month / day

Follow-up frequency:

Will the patient be referred to a psychiatrist? ☐ Yes ☐ No Name of physician:

Patient's cooperation in the treatment: ☐ excellent ☐ average ☐ poor

If you anticipate that the absence from work will exceed the usual period for such a diagnosis, please specify the factors justifying your prognosis.

Would your patient benefit from assistance within the scope of a return to work? ☐ Yes ☐ No

Do you consider that the patient's condition has improved in an optimal way? ☐ Yes ☐ No

Follow-up and prognosis (...continued)

Approximate duration of the disability: No. of days _____ No. of weeks _____

Unspecified ☐ or date of return to work: _____ / _____ / _____
year / month / day

How long before the patient will be able to return to work? No. of days No. of weeks

Part-time ☐ Full-time ☐ Gradual return ☐ Specify:

Questions specific to the contract

Part 3 - Identification of the physician

Family name, given name:

Telephone: Fax:

License number:

General practitioner ☐ Specialist ☐ Specify:

Signature : _____ Date :

NOTE : THE INSURED MUST PAY THE FEES REQUESTED TO COMPLETE THIS FORM.

Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6