Attending Physician Statement (APS)
Short Term Disability Application

Dear Claimant:

There are two parts to this form:
1) (Claimant Information and Authorization to Release Information) is to be completed by you.
2) (Physician Questionnaire) is for your physician to complete and fax back to TeksMed Services Inc. at 877.504.1777.

***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 in its entirety 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 877.850.1021 or email us at claims@teksmed.com

Complete and fax back to TeksMed Services Inc CONFIDENTIAL FAX: 877.504.1777

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 TeksMed Services 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 TeksMed Services 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 TeksMed Services Inc., or such designated agent or successor as may be appointed 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 TeksMed Services 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 TeksMed Services 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*** TeksMed Services Inc. ***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 II: _____
AXIS III: _____
AXIS IV: _____

AXIS V (GAF SCORE)
Current GAF Score: _____
Highest GAF Score in the past Year: _____
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:

_____

_____

_____

_____

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	☐	_____	☐
Standing Limitation	☐	_____	☐
Walking Limitation	☐	_____	☐
Limited repetitive use of upper limbs	☐	_____	☐
Other	☐	_____	☐

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 101 - 8615 Young Road, Chilliwack, BC V2P 4P3 **CONFIDENTIAL FAX: *877.504.1777***

For additional information, please contact us at 877.850.1021 or email us at claims@teksmed.com