SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

ATTENDING PHYSICIAN'S STATEMENT - PSYCHIATRIC

To allow us to make an assessment of your patient's file, please answer all of the questions in full. Incomplete responses or missing information will cause delays in the assessment and handling of this file. Any charge for completing this form is the patient's responsibility.

INSTRUCTIONS:

- Please print. Part 1 to be completed by patient, Part 2 to be completed by physician.
- Fax this completed form, along with any other pertinent documentation to **1.306.667.5495** or mail to (do not use staples) Saskatchewan Blue Cross, 516 2nd Avenue North, PO Box 4030, Saskatoon, SK S7K 3T2. **Please keep a copy of this form for your records.**

PART 1 - PATIENT AUTHORIZATION

Name	Policy Number	Identification Number
Date of Birth (YYYY/MM/DD)	Phone Number	Email
Address (Street Number and Name)	Apartment or Suite	City
Province	Country	Postal/Zip Code

I authorize the release of personal information and personal health information in my file by the healthcare provider listed on this form to Saskatchewan Blue Cross, Blue Cross Life Insurance Company of Canada and/or its authorized agents for the purposes of determining eligibility for coverage, underwriting, adjudicating and paying claims, administering products and services, audit and investigation. This personal information and personal health information includes, but it not limited to, copies of all consultation reports, my medical history, clinical notes, test results and hospital records. Medical and health information excludes genetic test results.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853.

Patient's Signature Date

PART 2 - ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS

Primary

Secondary

List all other conditions or complications affecting the duration of this absence from work:

Please provide your objective mental status on examination findings, including severity and frequency.

List subjective symptoms

Did you complete a mental status examination (including GAF, PHQ, GAD, etc)? ☐ Yes ☐ No
If yes, provide date and results:

2. HISTORY

(Please provide copies of all relevant clinical notes and consultation reports on file.)

When did symptoms start?

When did symptoms worsen?

Date patient stopped working due to this condition

Date of first visit for treatment or consultation

Date of most recent visit

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (Specify)

Has patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown
If yes, state when and describe:

Were work problems a factor in the development of your patient's condition? ☐ Yes ☐ No
If yes, please specify:

Have you completed provincial workers compensation plan claim forms? ☐ Yes ☐ No

Are patient's symptoms related to drug or alcohol or other substance abuse? ☐ Yes ☐ No

a) If yes, is patient enrolled in a substance abuse program? ☐ Yes ☐ No

b) If yes, state facility:

Has your patient ever been enrolled in a substance abuse program? ☐ Yes ☐ No
If yes, state when:

Treatment

Treatment Dates (YYYY/MM/DD)	For What Condition?	Treatment Provider or Facility (name, address, clinical specialty)

Date of hospital in-patient admission

Date of discharge

Date of hospital out-patient admission

Name of hospital

3. PRECIPITATING AND COMPLICATING FACTORS

Please describe all factors that may have contributed to the onset of the condition(s) or may complicate their resolution:

- ☐ Workplace issues
- ☐ Social/Family Issues
- ☐ Physical/Mental Condition
- ☐ Coping Skills
- ☐ Alcohol/Drug Abuse
- ☐ Personality/Motivation
- ☐ Other Issues (describe)
- ☐ Other Substance Abuse
- ☐ Financial/Legal Problems

Please describe supports in place or planned to address identified factors:

4. CURRENT TREATMENT

Type of therapy	Therapy goal
Frequency and length of therapy/counseling sessions	Number of therapy/counseling sessions to date (YYYY/MM/DD)
Please comment on treatment compliance	
Please comment on treatment response to date	Next Appointment Date (YYYY/MM/DD)

Patient Prognosis ☐ None ☐ Regressed ☐ Minimal Improvement ☐ Significant Improvement ☐ Plateaued ☐ Resolved

	Medication	Medication	Medication
Date Started (YYYY/MM/DD)			
Initial Dosage			
Initial Response			
Date of Last Dosage Change (YYYY/MM/DD)			
Current Dosage			
Response			
Side Effects			
Compliance			
Date Medication Discontinued (YYYY/MM//DD)			

(Please attach a list if more space is required)

5. REHABILITATION

What changes in your treatment plan are underway or are being considered?

Have you discussed return to work with your patient?

Please indicate your patients restrictions (what your patient should not do) and limitations (what your patient is unable to do)

Can your patient participate in a gradual or modified return to work plan?

Is your patient a suitable candidate for medical rehabilitation? ☐ Yes ☐ No

Is your patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No

If yes, please specify. If no, why not?

6. COMPETENCY

Do you believe your patient is competent to cash/cheques and use the proceeds? ☐ Yes ☐ No

If no, why not?

Have you referred the case to the Public Trustee? ☐ Yes ☐ No

Are there any other comments you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

7. Have you completed other requests regarding your patient's current medical condition to other sources? ☐ Yes ☐ No
i.e. other insurance providers, Canada Pension Plan, provincial workers compensation plan etc.?

If so, please provide details:

NOTICE TO PHYSICIAN

The information in this statement will be kept in a life, health or disability benefit file with the insurer or plan administrator and might be accessibly by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

Name of Physician (please print) | Specialty

Telephone | Fax Number | Email Address

Address | City | Province | Country

Physician's Signature | Date (YYYY/MM/DD)