

PHYSICIAN'S STATEMENT PRE-ESTABLISHED FORM LEAVE / DISABILITY INSURANCE

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TO BE COMPLETED BY THE EMPLOYEE (PLEASE PRINT)

EMPLOYEE NAME		EMPLOYEE N°	
DATE OF BIRTH	YEAR / MONTH / DAY	HOURS	PHONE
JOB TITLE	EMAIL	OTHER PHONE	

TO BE COMPLETED BY THE PHYSICIAN (PLEASE PRINT)

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE PATIENT.

1) DIAGNOSIS

A) MAIN _____

B) SECONDARY (RELATED TO THE LEAVE, IF APPLICABLE) _____

C) DESCRIPTION OF SIGNS AND SYMPTOMS AND DEGREE OF SEVERITY (L = LIGHT, M = MEDIUM, I = INTENSE)

SUBJECTIVE SYMPTOMS	L	M	I	OBJECTIVE SIGNS	L	M	I
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D) DATE FIRST SYMPTOMS APPEARED _____

YEAR / MONTH / DAY

 E) DATE WHEN AILMENT OR ACCIDENT FORCED
THE PATIENT TO STOP WORKING _____

YEAR / MONTH / DAY

F) DATE OF APPOINTMENT _____

YEAR / MONTH / DAY

G) DATE OF NEXT APPOINTMENT _____

YEAR / MONTH / DAY

 H) HAS THE PATIENT HAD THIS OR A SIMILAR AILMENT IN THE PAST? YES NO
IF YES, PLEASE SPECIFY DATES AND PROVIDE DETAILS. _____

I) THE AILMENT IS: _____

 DUE TO AN ILLNESS

 RELATED TO PSYCHOSOCIAL STRESSORS (TO BE COMPLETED ONLY FOR PSYCHOLOGICAL CONDITIONS)

 CONSEQUENTIAL TO A PERSONAL ACCIDENT / NATURE OF THE ACCIDENT _____

 CONSEQUENTIAL TO AN AUTOMOBILE ACCIDENT YEAR / MONTH / DAY OR A CRIMINAL ACT YEAR / MONTH / DAY

 PREGNANCY-RELATED EXPECTED DATE OF DELIVERY YEAR / MONTH / DAY

2) TREATMENT

A) MEDICATION – NAME AND DOSAGE _____

B) START OF MEDICATION OR DOSAGE ADJUSTMENT DATE YEAR / MONTH / DAY

C) ADDITIONAL TREATMENT PRESCRIBED _____

D) REFERRED TO A SPECIALIST _____

YEAR / MONTH / DAY

E) EXAMINATIONS OR TESTS, PLEASE SPECIFY (ATTACH A COPY OF THE RESULTS)

 YES NO _____

F) SURGERY, NATURE OF THE PROCEDURE AND DATE

 YES NO _____

YEAR / MONTH / DAY

G) HOSPITALIZATION

 YES NO FROM YEAR / MONTH / DAY TO YEAR / MONTH / DAY

 H) PATIENT'S GENERAL CONDITION: STABLE IMPROVED DETERIORATED

» » » **IMPORTANT** « « «

LOTO-QUÉBEC PROMOTES EMPLOYEE RETENTION AND READAPTATION BY PROVIDING ASSISTANCE AND LIGHTENING OR MODIFYING THE WORKLOAD AND SCHEDULE SO THE EMPLOYEE CAN RETURN TO WORK AS SOON AS THE MEDICAL CONDITION ALLOWS. THE INFORMATION YOU PROVIDE WILL HELP US DETERMINE WHETHER THE PATIENT CAN PROGRESSIVELY RETURN TO THEIR USUAL JOB POSITION OR WHETHER THEY MUST BE TEMPORARILY ASSIGNED TO OTHER TASKS.

3) PROGNOSIS AND FUNCTIONAL ABILITIES

CAN THE PATIENT PERFORM THEIR **USUAL DUTIES**?

NO

YES -----> A) START DATE YEAR / MONTH / DAY

B) IS A PROGRESSIVE RETURN TO WORK REQUIRED? NO YES
IF YES, SPECIFY _____

CAN THE PATIENT PERFORM **LIGHT WORK**?

NO, THE PATIENT CANNOT PERFORM **ANY WORK**

YES -----> A) WHAT RESTRICTIONS MUST THEY OBSERVE?

B) STARTING WHEN? YEAR / MONTH / DAY DURATION _____

C) IS A PROGRESSIVE RETURN TO WORK REQUIRED? NO YES

IF YES, SPECIFY _____

WHEN WILL THE PATIENT BE ABLE TO RESUME THEIR **USUAL DUTIES**? YEAR / MONTH / DAY

4) PHYSICIAN'S INFORMATION

PHYSICIAN'S NAME	PRACTICE NUMBER	PHONE
ADDRESS	NAME OF CLINIC OR HEALTH FACILITY	
CITY		POSTAL CODE
PHYSICIAN'S SIGNATURE	YEAR / MONTH / DAY	FAX

5) EMPLOYEE'S AUTORIZATION

I authorize the physician to contact Loto-Québec health care staff and share any relevant information required to analyze and assess my claim for disability or medical restrictions. Such authorization will remain in effect throughout my disability period or the time needed to process my medical restrictions. I agree that any photocopy or electronic transmission of this authorization will have the same value as the original.

EMPLOYEE'S SIGNATURE

YEAR / MONTH / DAY

NOTE TO THE EMPLOYEE

The attending physician's statement must be emailed to invalidites@loto-quebec.com. Form fees for CNESST claims will not be refunded.