UV INSURANCE
P.O. Box 696, Drummondville, Quebec J2B 6W9
1 800 567-0988 | Fax 819 474-1990 | uvinsurance.ca

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Physical illnesses

Note: For psychological illnesses, complete the form on the reverse

Original request

The insured must complete this section

❶ Family name: _____ ❷ Given name: _____

❸ Contract no.: _____ (Group or Contract no.) _____ (Certificat no.)

❹ Social insurance number: _____

❺ Date of birth: Y Y Y Y M M D D

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____

1.2 Secondary: _____

1.3 Complications: _____

1.4 For the illnesses or associated symptoms diagnosed, has the patient previously:

a) received medical treatments ☐ b) consulted another physician ☐ c) taken drugs ☐ d) been hospitalized ☐ e) undergone examinations ☐

Specify the periods: _____

1.5 Is the disability related to: an accident ☐ an illness ☐ an occupational accident ☐ an automobile accident ☐

Date of the event: Y Y Y Y M M D D

a pregnancy No ☐ Yes ☐

a preventive withdrawal from work No ☐ Yes ☐ Scheduled date of delivery: Y Y Y Y M M D D

1.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.

At the beginning of disability Y Y Y Y M M D D Currently

2. Treatment

2.1 Drugs - name- dosage _____

2.2 Has the patient undergone or will undergo:

a) examinations or tests No ☐ Yes ☐ Specify: _____

b) surgery No ☐ Yes ☐ day surgery ☐ Type _____

surgical procedure: _____ Date: Y Y Y Y M M D D

c) other treatments? No ☐ Yes ☐ Specify: _____

d) hospitalization: from _____ to _____ Name of hospital: _____

e) a short stay under observation (number of hours): _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Dates of other consultations: _____ Follow-up frequency: _____

3.3 Referral to another physician: No ☐ Yes ☐ Name of physician: _____

Specialty: _____

3.4 Approximate duration of disability: No. of days ____ No. of weeks ____ unspecified ☐ or date of return to work Y Y Y Y M M D D

3.5 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: _____

4. Questions specific to the contract

4.1 In the last five years, has the patient consulted or been treated by a physician or other practitioner, or taken any prescribed drugs for one or any of the following illnesses: cancer or tumor, diabetes, high blood pressure, Crohn's disease, drug addiction or alcoholism, nervous or mental disorders, pulmonary disorder, kidney or genital disorders, cerebral or neurological disorder, musculoskeletal disorders, AIDS related illnesses, or the presence of antibodies to the HIV virus?

No ☐ Yes ☐ **If yes**, please provide us with the following information:

Illnesses:	Dates:	Results:	Dates hospitalized:	When has the patient been informed of his condition:

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: _____

5.2 License number: _____ Fax: _____

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: Y Y Y Y M M D D

573-A (11-12)

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

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Psychological illnesses

Note: For physical illnesses, complete the form on the reverse

Original request

The insured must complete this section

❶ Family name: _____ ❷ Given name: _____

❸ Contract no.: _____ (Group or Contract no.) _____ (Certificat no.)

❹ Social insurance number: _____

❺ Date of birth: Y Y Y Y M M D D

Declaration of the attending physician (Complete in block letters and give to the patient)

1. Diagnosis

1.1 Principal: _____

1.2 Secondary: _____

1.3 Current symptoms: _____

1.4 Degree of severity of all symptoms: Mild ☐ Moderate ☐ Severe ☐ with psychotic elements ☐

1.5 Does the interruption of work result from problems related to:

☐ marital/family life ☐ loss of employment or layoff ☐ professional problems

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

☐ other problems, specify: _____

1.6 For the illnesses or associated symptoms diagnosed, has the patient previously:

a) received medical treatments ☐ b) consulted another physician ☐ c) taken drugs ☐ d) been hospitalized ☐ e) undergone examinations ☐

Specify the dates of previous episodes: _____

2. Treatment

2.1 Drugs - name- dosage: _____

2.2 Is the patient consulting a psychiatrist? No ☐ Yes ☐ a social worker? No ☐ Yes ☐

a psychologist? No ☐ Yes ☐ another health care provider? No ☐ Yes ☐

If yes, name of the caregiver: _____

2.3 Hospitalization: from _____ to _____ Name of hospital: _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Y Y Y Y M M D D Next consultation: Y Y Y Y M M D D

3.2 Dates of other consultations: _____

3.3 Follow-up frequency: _____

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

3.5 Approximate duration of disability: No. of days ____ No. of weeks ____ unspecified ☐ or date of return to work Y Y Y Y M M D D

3.6 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: _____

4. Questions specific to the contract

4.1 In the last five years, has the patient consulted or been treated by a physician or other practitioner, or taken any prescribed drugs for one or any of the following illnesses: cancer or tumor, diabetes, high blood pressure, Crohn's disease, drug addiction or alcoholism, nervous or mental disorders, pulmonary disorder, kidney or genital disorders, cerebral or neurological disorder, musculoskeletal disorders, AIDS related illnesses, or the presence of antibodies to the HIV virus?

No ☐ Yes ☐ **If yes**, please provide us with the following information:

Illnesses:	Dates:	Results:	Dates hospitalized:	When has the patient been informed of his condition:

5. Identification of the physician

5.1 Family name, given name: _____ Telephone: _____

5.2 License number: _____ Fax: _____

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: Y Y Y Y M M D D

573-A (11-12)

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