ORGANIZATIONAL SOLUTIONS INC.
SOLUTIONS ORGANISATIONNELLES INC.

Attending Physician Statement (APS)

t: 1-866-674-7656; **f:** 1-866-511-0008; **e:** info@orgsoln.com

In order for an absence to qualify under the Employer's Short Term Disability plan, the medical documentation must contain objective clinical findings and detailed medical information which establishes the presence of a medical condition and treatment including objective evidence of an impairment severe enough to prevent your patient / client from participating in work.

This employee is applying for Short Term Disability under the Employer's Short Term Disability / Sick Leave plan.

- It is the employee's responsibility to provide medical information to support an absence. The cost incurred in obtaining this information is the responsibility of the employee.
- Failure to submit this information promptly may result in the suspension of income for your patient / client.
- This is not a request for examination, but for information taken from your clinical assessment.

If absence is related to surgery, this form is to be completed after the surgery has been done.

Once completed, please send to Organizational Solutions Inc.'s confidential fax at 1-866-511-0008 or scan / email to info@orgsoln.com. For additional information, please contact us at 1-866-674-7656.

1 Employee Information - To be Completed by the Employee : Page 1 of 4

Employer Name:			
Employee First Name:	Last Name (Quebec residents include maiden name):		
Employee Number:	Date of Birth: ____ / ____ / _____ (MM / DD / YYYY)	Home Telephone:	Work Telephone:
Cell Phone:		Email Address:	
Home Address:		Occupation:	
Immediate Supervisor's Name:		Telephone:	
Please describe the nature of illness or injuries sustained:			

Is your illness or injury due to an accident?: Yes ☐ No ☐

IF YES: 1) Did the accident happen at: Home ☐ Work ☐ Elsewhere ☐

Date and Time of accident: ____ / ____ / _____ (MM / DD / YYYY) at _____

2) Have you or will you be applying for Workers' Compensation / CNESST? Yes ☐ No ☐

3) Is your illness or injury due to a motor vehicle accident? Yes ☐ No ☐ If yes, enclose a copy of the accident report.

4) Date of first absence: ____ / ____ / _____ (MM / DD / YYYY)

5) Have you ever had the same or similar condition? Yes ☐ No ☐

When did you seek medical attention? ____ / ____ / _____ (MM / DD / YYYY)	Date you returned to work or expect to return to work: ____ / ____ / _____ (MM / DD / YYYY)

Disability Type: Illness ☐ Injury ☐ Work Injury ☐ Motor Vehicle Accident ☐ Pregnancy ☐

2 Authorization to Release Information

I certify that the statements in this form are true and complete.

I authorize Organizational Solutions Inc., and their respective agents and service providers to use and exchange information needed for providing advice to my employer concerning my absence under my employer's Short Term Disability / Sick-Leave plan, with any person or organization who has relevant information pertaining to my absence, including health professionals, institutions, and insurers.

I hereby authorize health care provider(s), health care professional(s), institutions, or the LTD Insurer / WCB involved in my treatment or claim to discuss and provide all information and documents requested by the Employer and / or, Organizational Solutions Inc., their representatives, concerning my current medical or psychological health condition. I authorize Organizational Solutions Inc. to release and discuss information with the Insurer, WCB, administrators of government benefits, health care practitioners, or health care providers. Medical Information will be treated in a highly confidential manner. Information necessary to determine eligibility, my abilities, and my return to work capabilities will be shared with my employer. I understand that aggregate data is compiled and used to support evidence based studies.

I agree that an electronic, facsimile or a photocopy is to be considered as valid as an original signed copy.

Employee Signature : _____ Date : ____ / ____ / _____ (MM / DD / YYYY)

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3 Physician Questionnaire

Dear Physician: The Employer is interested in supporting ill and injured employees in their recovery and a safe, timely return to work. We ask you to complete the few questions below so that the employee can return this form as soon as possible via fax 1-866-511-0008.

There is an option to complete this form online at : https://portal.orgsoln.com (Username: Physician / Password: APS#4523)

History

Date of 1st visit: ___ / ___ / _____ Date most recent visit: ___ / ___ / _____ Date last worked: ___ / ___ / _____

When did symptoms first appear or accident first happen?: ___ / ___ / _____

Has your patient ever had the same or similar condition: Yes ☐ No ☐ Unknown ☐

If yes - State when and describe: _____

Frequency of symptoms over the past six months: _____

Physical findings: _____

Names and specialties of other treating physicians (Please attach copies of consultation reports) :

Name	Specialty	Frequency of Visits / Treatments	Dates

For PSYCHIATRIC diagnosis please proceed to page 4 and complete. Signature required on Page 3

Diagnosis (including complications)

Primary: _____ Secondary: _____

Co-morbid conditions or complications: _____

If Obstetrical diagnosis: Expected date of confinement: ___ / ___ / _____ Is patient confined to bedrest: Yes ☐ No ☐

Signs and Symptoms: _____

_____

Objective and clinical findings – Please be specific – pertinent physical findings (include severity, frequency):

_____

_____

If diagnosis is musculoskeletal in nature, please indicate neurological findings:

		Comments:
Area(s) affected:	Right ☐ Left ☐ Both ☐	_____
Reflexes:	Right ☐ Left ☐ Both ☐	_____
Weakness present:	Yes ☐ No ☐	_____
Muscle wasting noted:	Yes ☐ No ☐	_____
Decreased sensation or numbness:	Yes ☐ No ☐	_____
Positive Tinel's or Phalen's sign:	Yes ☐ No ☐	_____
Radiating Pain?:	Please describe:	_____

Does your patient exhibit pain focused behaviors?:Yes ☐ No ☐ _____

Treatment Plan

Hospital Admission – Admission Date: ___ / ___ / _____ Discharge Date: ___ / ___ / _____

Surgery: Yes ☐ No ☐ Date: ___ / ___ / _____ Surgical procedure: _____

Please complete the type of diagnostic testing completed or pending: _____Date: ___ / ___ / _____

Medication (attach page if required):

Name	Dose	Date Begun	Date Changed and Reason	Response

Employee Name: _____

Date: ___ / ___ / _____

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Physician Questionnaire (Continued)

Current and proposed treatment – include type, frequency and duration:

_____

_____

Has a referral for physiotherapy been made? Yes ☐ No ☐ Start date for Physiotherapy: ___ / ___ / _____

Compliance – Is your patient compliant with the recommended treatment program? Yes ☐ No ☐

Functional Capacity

PLEASE PROVIDE CURRENT CAPABILITIES Estimated Duration: _____

MOBILITY	RARELY ABLE (0-5%)	OCCASIONALLY ABLE (6-33%)	FREQUENTLY ABLE (34-66%)	CONSTANTLY ABLE (67-100%)	FULL ABILITY
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Continuous Bending / Twisting	☐	☐	☐	☐	☐
Kneeling / Crouching / Squatting	☐	☐	☐	☐	☐
LIFTING FLOOR TO WAIST					
Sedentary (up to 4.5 kgs)	☐	☐	☐	☐	☐
Light (4.6 - 9.0 kgs)	☐	☐	☐	☐	☐
Medium (9.1 – 22 kgs)	☐	☐	☐	☐	☐
LIFTING WAIST TO SHOULDER					
Sedentary (up to 4.5 kgs)	☐	☐	☐	☐	☐
Light (4.6 - 9.0 kgs)	☐	☐	☐	☐	☐
Medium (9.1 – 22 kgs)	☐	☐	☐	☐	☐
OFFICE SKILLS					
Computer Use / Mousing	☐	☐	☐	☐	☐
Typing	☐	☐	☐	☐	☐
Writing	☐	☐	☐	☐	☐

UPPER BODY	Right	Left	Both	Right	Left	Both	Right	Left	Both	Right	Left	Both	Right	Left	Both
Pushing / Pulling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gripping / Grasping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reaching forward (over 45 cm)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reaching overhead (over 178 cm)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Is your patient able to operate a motor vehicle?: Yes ☐ No ☐

If no, has inability to operate a motor vehicle been reported to Ministry of Transportation?:Yes ☐ Date:___ / ___ / _____ No ☐

Prognosis

What is the prognosis for return to regular unrestricted work?: _____

What are the factors affecting your patient's progress?: _____

Date of next appointment: ___ / ___ / _____ Is complete recovery expected? Yes ☐ No ☐

Notice to Physician Any information provided by me to OSI regarding this claim may be disclosed to the Employee and / or those authorized by him / her to receive such disclosure unless I notify OSI in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect to the health of the Employee or result in harm to a third party.

Physician Signature: _____ Print Physician name: _____ Date:___ / ___ / ____

Specialty: _____Street: _____ City:_____ Province: _____ Postal Code:_____

Telephone Number: _____ Fax Number: _____ License Number: _____

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4 Complete this section if diagnosis is PSYCHIATRIC in nature

Psychiatric Diagnosis / Reason for visit per DSM-V: _____

Secondary diagnosis (if applicable): _____

Are patient's symptoms due to drug or alcohol abuse?: Yes ☐ No ☐ If yes, details: _____

Hospital admission or substance abuse program?: Yes ☐ No ☐ If yes, details: _____

Signs and Symptoms: _____

_____

Depression Test Questionnaire score(PHQ-9) _____ Generalized Anxiety Disorder score (GAD-7): _____

DSM-V Code(s):_____ Severity: Mild ☐ Moderate ☐ Severe ☐ Date of Onset: ___ / ___ / ____

Cognitive Mental Impairment: Does your patient have a cognitive / mental limitation? Yes ☐ No ☐ If yes, complete this section.

Indicate if the patient currently has cognitive / mental restrictions in the following areas:	NO IMPAIRMENT	MILD IMPAIRMENT	MODERATE IMPAIRMENT	SEVERE IMPAIRMENT
Verbal Communication	☐	☐	☐	☐
Attention to Detail	☐	☐	☐	☐
Concentration (e.g. attention, orientation)	☐	☐	☐	☐
Able to follow and provide instructions	☐	☐	☐	☐
Completion of time sensitive duties	☐	☐	☐	☐
Working alone / in isolation	☐	☐	☐	☐
Comprehension	☐	☐	☐	☐
Analytical Reasoning (e,g, judgement)	☐	☐	☐	☐
Learning new material (e.g. Memory)	☐	☐	☐	☐
Social Interaction (e.g. mood)	☐	☐	☐	☐
In your opinion, is your patient competent to manage his / her own affairs? Yes ☐ No ☐				
Remarks:				

Additional functional limitations that may apply to the diagnosis?: _____

_____

Is your patient able to perform their normal Activities of Daily Living (ADL)?: Yes ☐ No ☐

If no, please provide details as to how your patient's medical condition impacts their ability to perform their ADLs:

_____

How often is your patient being evaluated?: _____

Please confirm if any other medical conditions have been ruled out as contributing to or causing the current mental health condition(s): _____

Medication (attach page if required):

Name	Dose	Date Begun	Date Changed and Reason	Response

Referral to therapy / counselling?: Yes ☐ No ☐ If yes, provide name and details: _____

_____

Referral to Psychiatrist?: Yes ☐ No ☐ If yes, provide name and details: _____

_____

If yes, provide next appointment date: ___ / ___ / _____ Date referral was made: ___ / ___ / _____

If no, provide rationale: _____

Are there any psychological stressors that may affect return to work? Yes ☐ No ☐

Psychosocial and environmental problems: Yes ☐ No ☐ Workplace Issues: Yes ☐ No ☐

Comments: _____

Please provide recommendations to assist your patient in a safe and suitable return to work: _____

_____