

Patient Authorization
(This section must be completed and signed by patient to authorize release of medical information).

Employee number Contract number
50740

The Corporation of the City of Mississauga
Attending Physician Statement
Weekly Indemnity: Psychiatric

Name - given and last name Date of birth
I authorize the release to Sun Life Assurance Company of Canada of any information in respect of this claim.

Employee signature Date

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.

General Information

This form must be completed by a doctor of medicine

Is patient's condition due to injury or sickness caused by employment?	Last day at work	First day patient seen	Expected duration of disability
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Date of hospital in-patient admission	Date of discharge	Patient referred to you?	Name of referring physician
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you referred patient?	Name of physician(s)/other	Telephone	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of first and all subsequent visits during present period of absence from work	Date first unable to work because of disability	Is patient competent to endorse cheques?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Diagnosis

Please use DSM-IV terminology, including multi-axial assessment and general assessment of function GAF

Axis 1 (Primary)

Axis 2 (Secondary)

Axis 3

Axis 4

Axis 5

GAF current lowest in past year

History

List all relevant symptoms (noting severity, date of onset and progression) and describe how this affects daily living and work

Treatment Plan

List medications, dosage frequency and results

Counseling (first appointment, last appointment, frequency, results)

Remarks

Comment on relevant personal, work, family history or any external factors influencing this claim

Prognosis

Please note any restrictions and/or limitations, and state prognosis

Name of attending physician (please print)	Specialty	Telephone	Fax
Address			
Physician's signature			Date

Please fax or mail to:

Toronto:
Fax: (416) 595-5243
 PO Box 950 Str A
 Toronto ON M5W 1G5