La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856
Fax: 418 643-7323 or 1 855 669-8830
prest.inv@lacapitale.com (unsecured transmission mode)

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Initial Application

PHYSICAL ILLNESSES

Section to be completed by the Insured

Note: For psychological illnesses, complete the reverse of this form.

1 Last Name: _____ 2 First Name: _____

3 Group No. / Identification No.: _____ 4 Date of Birth: Year Month Day

Attending Physician's Declaration (Complete in block letters and give to the patient)

Please send us a copy of the entire medical file of your patient since the leave of absence, including test results and specialist reports, not including genetic test results.

1. Diagnosis

1.1 Primary: _____

1.2 Secondary: _____

1.3 Complications: _____

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

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

Specify periods: _____

1.5 Please specify whether the incapacity is related to: An accident ☐ An illness ☐ An occupational accident ☐ An automobile accident ☐

Date of the event: Year Month Day

Pregnancy No ☐ Yes ☐

A preventive withdrawal from work No ☐ Yes ☐ Expected date of delivery: Year Month Day

1.6 Describe the functional limitations preventing the patient from carrying out her professional duties or usual tasks.

At the start of disability Year Month Day Currently

2. Treatment

2.1 Drugs – name – dosage: _____

2.2 Specify if the patient has undergone or will undergo:

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

b) An operation No ☐ Yes ☐ Day surgery ☐ Type _____

Surgical procedure: _____ ↳ Date: Year Month Day

c) Other treatments: No ☐ Yes ☐ Specify: _____

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

e) A short stay under observation: No ☐ Yes ☐ (No. of hours): _____

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Year Month Day Next consultation: Year Month Day

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 _____ Indefinite ☐ or Date of return to work Year Month Day

3.5 How long before the patient is likely to be able to return to work? No. of days _____ No. of weeks _____

Part time ☐ Full time ☐ Gradual return ☐ Specify: _____

4. Other comments

5. Identification of physician

5.1 Last name, first name: _____ Tel.: _____

5.2 License No.: _____ Fax: _____

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: Year Month Day

NOTE: THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED TO HAVE THIS FORM COMPLETED.

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Initial Application

PSYCHOLOGICAL ILLNESSES

Section to be completed by the Insured

Note: For physical illnesses, complete the reverse of this form

1 Last Name: _____ 2 First Name: _____

3 Group No. / Identification No.: _____ 4 Date of Birth: Year Month Day

Attending Physician's Declaration (Complete in block letters and give to the patient)

Please send us a copy of the entire medical file of your patient since the leave of absence, including test results and specialist reports, not including genetic test results.

1. Diagnosis

1.1 Primary: _____

1.2 Secondary: _____

1.3 Current symptoms: _____

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

1.5 Describe the functional limitations preventing the patient from carrying out her professional duties or usual tasks.

At the start of disability	Currently

1.6 Specify whether the patient's absence from work is due to problems related to:

☐ Marital/family life ☐ Loss of employment or layoff ☐ Occupational problems

☐ Personal or interpersonal problems ☐ Alcohol or drug abuse and/or gambling problems

☐ Other, specify: _____

1.7 For the illnesses or related symptoms diagnosed, has the patient previously:

a) received medical treatment ☐ c) taken drugs ☐ e) undergone examinations ☐

b) consulted another physician ☐ d) been hospitalized ☐

Please specify dates of any previous episodes: _____

2. Treatment

2.1 Drugs – name – dosage:

2.2 Specify whether the patient is consulting:

A psychiatrist	No ☐	Yes ☐	A social worker	No ☐	Yes ☐
A psychologist	No ☐	Yes ☐	Another health care provider	No ☐	Yes ☐

If yes, name of service provider: _____

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

3. Follow-up and prognosis

3.1 Date of first consultation for this disability: Year Month Day Next consultation: Year Month Day

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 _____ Indefinite ☐ or Date of return to work Year Month Day

3.5 How long before the patient is likely to be able to return to work? No. of days _____ No. of weeks _____

Part time ☐ Full time ☐ Gradual return ☐ Specify: _____

4. Other comments

5. Identification of physician

5.1 Last name, first name: _____ Tel.: _____

5.2 License No.: _____ Fax: _____

General practitioner ☐ Specialist ☐ Specify: _____

Signature: _____ Date: Year Month Day

NOTE: THE INSURED IS RESPONSIBLE FOR ANY FEES CHARGED TO HAVE THIS FORM COMPLETED.