La Capitale

625 Jacques-Parizeau St.
P.O. Box 16040
Quebec QC G1K 7X8

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Original request

PHYSICAL ILLNESSES

The insured must complete this section

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

1. Last name: ___
2. First name: ___
3. Contract no.: ___
4. Social insurance number: ___
5. Date of birth: Year Month Day

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: Year Month Day

a pregnancy No ☐ Yes ☐

a preventive withdrawal from work No ☐ Yes ☐ Scheduled date of delivery: Year Month Day

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

At the beginning of disability Year Month Day | 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: Year Month Day

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: 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 ___ unspecified ☐ or date of return to work Year Month Day

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 Within the last five years, has the patient consulted or been treated by a physician or other practitioner, or took drugs prescribed by a physician for any of the following illnesses or conditions: cancer or tumor, diabetes, high blood pressure, Crohn's disease, ulcerative colitis, disorder of the heart or blood vessels, alcohol or drug abuse, nervous or mental illnesses, pulmonary disorders, disorders of the kidneys or urinary disorders, cerebral or neurological disorders, disorders of the spine, AIDS related diseases, or had tests results indicating exposure to AIDS virus?

No ☐ Yes ☐ **If yes,** please give the following information:

Diseases	Dates	Results	Periods of hospitalization	When the patient has been informed of his disease?

4.2 ___

5. Identification of the physician

5.1 Last name, first name: ___ Telephone: ___

5.2 License number: ___ Fax: ___

General practitioner ☐ Specialist ☐ Specify: ___

Signature: ___ Date: Year Month Day

M311-A (11-2017)

La Capitale Civil Service Insurer Inc.

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

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FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

RACQ

Original request

PSYCHOLOGICAL ILLNESSES

The insured must complete this section

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

1 Last name:
2 First name:
3 Contract no.:
4 Social insurance number:
5 Date of birth: Year Month Day

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 ☐ c) taken drugs ☐ e) undergone examinations ☐
b) consulted another physician ☐ d) been hospitalized ☐

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: Year Month Day Next consultation: Year Month Day
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 Year Month Day
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 Within the last five years, has the patient consulted or been treated by a physician or other practitioner, or took drugs prescribed by a physician for any of the following illnesses or conditions: cancer or tumor, diabetes, high blood pressure, Crohn's disease, ulcerative colitis, disorder of the heart or blood vessels, alcohol or drug abuse, nervous or mental illnesses, pulmonary disorders, disorders of the kidneys or urinary disorders, cerebral or neurological disorders, disorders of the spine, AIDS related diseases, or had tests results indicating exposure to AIDS virus?

No ☐ Yes ☐ **If yes,** please give the following information:

Diseases	Dates	Results	Periods of hospitalization	When the patient has been informed of his disease?

4.2

5. Identification of the physician

5.1 Last name, first name: Telephone :
5.2 License number: Fax:
General practitioner ☐ Specialist ☐ Specify:

Signature: Date: Year Month Day

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