

Physician's Statement of Disability

Jan 2017



Complete both pages of this form. Section 1 should be completed by the member. Sections 2 to 9 should be completed by the attending physician. Please print or type. Attach additional sheets if more space is required.

1. Member Information

first name: last name: middle initials:

SIN: occupation:

I authorize the release of any medical information requested by HOOPP or its authorized representatives to determine my eligibility for disability benefits. I also acknowledge that I am responsible for any charges related to the completion of this form. I authorize HOOPP to collect, use and disclose my personal information for the purpose of assessing my disability application and administering my disability benefits, if applicable.

Signature of member: _____ Date:
mm/dd/yyyy

2. Physician Information

Please complete this form to help us accurately assess the medical condition of the HOOPP member named above. Any charges for the completion of this form are the responsibility of the member.

physician's name: address:

specialty (if any): phone: fax:

3. Diagnosis

primary: _____

secondary: _____

other contributory factors: _____

4. History

Date you first treated patient: Date you last treated patient:
mm/dd/yyyy mm/dd/yyyy

How often do you see this patient? weekly biweekly monthly other (specify): _____

Has your patient been referred to any other physicians/specialists? yes no If yes, complete the following chart:

| physician's/specialist's name | specialty | examination date | findings (include consultation reports, if possible) |
|-------------------------------|-----------|------------------|--|
| | | | |
| | | | |
| | | | |

mm/dd/yyyy

Healthcare of Ontario Pension Plan

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- Send to HOOPP
- Keep a copy for your files

5. Observations and Findings Based on your most recent examination of the patient, please report the following:

height: _____ weight: _____ blood pressure: _____

Significant physical findings:

Lab reports, diagnostic imaging, or other relevant tests that support the patient's disability:

6. Functional Limitations

| | | | | | | |
|-----------------------------|--------------|--|--------------------|--|---------------|--|
| Special senses: | hearing | yes <input type="checkbox"/> no <input type="checkbox"/> | equilibrium | yes <input type="checkbox"/> no <input type="checkbox"/> | vision | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Psychological: | mood changes | <input type="checkbox"/> <input type="checkbox"/> | coping with stress | <input type="checkbox"/> <input type="checkbox"/> | concentration | <input type="checkbox"/> <input type="checkbox"/> |
| Cardiorespiratory: | breathing | <input type="checkbox"/> <input type="checkbox"/> | exertion | <input type="checkbox"/> <input type="checkbox"/> | stamina | <input type="checkbox"/> <input type="checkbox"/> |
| Orthopedic: | joint motion | <input type="checkbox"/> <input type="checkbox"/> | standing | <input type="checkbox"/> <input type="checkbox"/> | lifting | <input type="checkbox"/> <input type="checkbox"/> |
| Neurological: | coordination | <input type="checkbox"/> <input type="checkbox"/> | memory/thinking | <input type="checkbox"/> <input type="checkbox"/> | pain | <input type="checkbox"/> <input type="checkbox"/> |
| Activities of daily living: | eating | <input type="checkbox"/> <input type="checkbox"/> | dressing | <input type="checkbox"/> <input type="checkbox"/> | walking | <input type="checkbox"/> <input type="checkbox"/> |

7. Treatments

Current medications: _____

Physiotherapy/other: _____

Has the patient had surgery? _____

Is surgery planned? _____

Is the patient following the prescribed treatment? _____

What is the patient's response to the treatment? _____

Specify type and date of any planned future treatment: _____

8. Prognosis

Would the patient be able to return to work at his or her own occupation full time? yes no Part time? yes no

Would the patient be able to return to work at any occupation full time? yes no Part time? yes no

If "no" to the previous questions, identify specific medical limitations that would prevent the patient from working:

Expected return to work date (full duties):
mm/dd/yyyy

Would vocational counselling or rehabilitation result in a return to gainful employment? yes no

9. Certification

I hereby certify that the information provided on this form is accurate and complete to the best of my knowledge.

Signature of physician: _____

Date:
mm/dd/yyyy