Physician's Statement of Continuing Disability

Jan 2017

HOOPP Healthcare of Ontario Pension Plan

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: | former 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. Attending 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. Progress

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

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

Have you ever completed a report for HOOPP on this patient? ☐ yes ☐ no

If yes, describe the patient's medical condition since the last report: ☐ improved ☐ unchanged ☐ worse

Provide relevant medical details of any change in condition:

Has this 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

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:

_____

Specify type and date of any planned future investigations: _____

6. Functional Limitations

		yes	no		yes	no		yes	no
Special senses:	hearing	☐	☐	equilibrium	☐	☐	vision	☐	☐
Psychological:	mood changes	☐	☐	coping with stress	☐	☐	concentration	☐	☐
Cardiorespiratory:	breathing	☐	☐	exertion	☐	☐	stamina	☐	☐
Orthopedic:	joint motion	☐	☐	standing	☐	☐	lifting	☐	☐
Neurological:	coordination	☐	☐	memory/thinking	☐	☐	pain	☐	☐
Activities of daily living:	eating	☐	☐	dressing	☐	☐	walking	☐	☐

7. Treatments

Current medications: _____

_____

Physiotherapy/other: _____

Has the patient had surgery? (list type/date): _____

Are any surgeries planned? (list type/date): _____

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

Healthcare of Ontario Pension Plan

1 York Street, Suite 1900
Toronto, Ontario M5J 0B6

Tel: 416-646-6445
Toll-free: 1-877-43HOOPP (46677)
Fax: 416-369-0225

hoopp.com
clientservices@hoopp.com

- Send to HOOPP
- Keep a copy for your files