Homewood Health | Santé

Name (Last, First)	
Case Number	
DOB (mm,dd,yyyy)	

Return to Work Services - Attending Physician's Statement - Short Term Disability Claim

Employee Information and Consent To Be Completed by the Employee (Please print)

Employee Name: (Last, First, Middle Initial)	Employer:	
Home Phone Number: (+ Area Code)	Cell Phone Number: (+ Area Code)	☐ Male ☐ Female
Address: (Street, City, Province, Postal Code)		
Job Title	Email Address	Preferred Language: ☐ English ☐ French
Date of Birth: (mm/dd/yyyy)	Last Day Worked: (mm/dd/yyyy)	

Employee's Authorization for Release of Information

I hereby authorize Homewood Health Inc. (HHI) to collect, use and disclose all information and documents pertaining to my Short Term Disability (STD) case with any physicians, therapists and other health care providers for the purpose of determining my eligibility for benefits and managing my medically supported absence. I also authorize HHI to collect, use and disclose information about me within the HHI organization and with any physicians, treatment providers, service providers or medical and para-medical professionals for the purpose of facilitating optimal care and for planning and managing my return to work. I further authorize HHI to provide all related medical information to the insurance carrier should I need to apply for Long Term Disability (LTD) benefits. I understand that only the information relating to my ability to work will be shared with my employer; **no medical information will be shared with my employer**. All information will be handled in accordance with applicable Privacy Legislation.

It is important to note that, in cases where safety or risk of life to yourself or others is a concern, HHI is required to take responsible action. This may mean notification to a spouse, physician or other authorities. If you are working in a Safety Sensitive Position, this will also mean notification to your employer or union. The reason for this is to assist in reducing the risk of harm to yourself, your co-workers and the public in general.

I agree that my consent is valid for the duration of my claim or during any appeal process, but for the purposes of audit, for the duration of the plan. I understand that I can revoke this consent at any time, but that without it my claim may not be assessed and HHI's ability to assist with my recovery and return to work may be impeded. I agree that a photocopy of this authorization or electronic version is as valid as the original.

I certify that the statements in this form are true and complete.

Employee Signature: _____ Date: _____

Dear Attending Physician

Your patient's employer is interested in supporting ill and injured employees in their recovery and ensuring a safe, timely return to work. Homewood Health Inc. has been retained by the employer to review your patient's medical absence to determine when the patient is able to return to work safely and to co-ordinate the patient's recovery and return to work. The purpose of this statement is to assist HHI in determining your patient's eligibility for STD benefits and for planning and managing an early and safe return to work. Any fee required for completion of this form is the responsibility of the patient. Your assistance is greatly appreciated.

Homewood Health | Santé

Name (Last, First)									
Case Number									
DOB (mm,dd,yyyy)									

To Be Completed by the Physician (Please Print)

Patient Name:	Date of Birth: (mm/dd/yyyy)

Nature of Illness – Please select appropriate ICD10 Diagnostic Category :

☐	A00-B99	Certain infectious and parasitic diseases
☐	C00-D49	Neoplasms
☐	D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
☐	E00-E89	Endocrine, nutritional and metabolic diseases
☐	F01-F99	Mental, Behavioral and Neurodevelopmental disorders
☐	G00-G99	Diseases of the nervous system
☐	H00-H59	Diseases of the eye and adnexa
☐	H60-H95	Diseases of the ear and mastoid process
☐	I00-I99	Diseases of the circulatory system
☐	J00-J99	Diseases of the respiratory system
☐	K00-K95	Diseases of the digestive system
☐	L00-L99	Diseases of the skin and subcutaneous tissue
☐	M00-M99	Diseases of the musculoskeletal system and connective tissue
☐	N00-N99	Diseases of the genitourinary system
☐	O00-O9A	Pregnancy, childbirth and the puerperium
☐	Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities
☐	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
☐	S00-T88	Injury, poisoning and certain other consequences of external causes

Primary Diagnosis:	
Secondary Diagnosis and/or Complications:	
If childbirth, expected or actual delivery date: (mm/dd/yyyy)	☐ Vaginal ☐ C-section
Occupational Illness/Injury: ☐ Yes ☐ No	If yes, date of event: (mm/dd/yyyy)
Auto accident: ☐ Yes ☐ No	If yes, date of event: (mm/dd/yyyy)
Date of first visit to you pertaining to this condition:	First date of work absence due to condition:
Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No	If yes, date: (mm/dd/yyyy)

Homewood Health | Santé

Name (Last, First)									
Case Number									
DOB (mm,dd,yyyy)									

Hospitalization Is/Was patient hospitalized: ☐ Yes ☐ No

Date of Admittance (mm/dd/yyyy): _____ Date of Discharge (mm/dd/yyyy): _____

If surgery was performed please provide date and description of surgery:

Date: (mm/dd/yyyy)_____ Description: _____

Treatment (Medication, Dosage, Physiotherapy, Other):

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Prognosis Please provide the prognosis for recovery:

Estimated date for return to full duties and hours of work: (mm/dd/yyyy)

Date of next appointment with you: (mm/dd/yyyy)

Patient Name: (in the event these pages get separated)

Please indicate if your patient has or will be seen by a specialist for this condition: ☐ Yes ☐ No

Name of Specialist:	Specialty:	Date of Visit: (mm/dd/yyyy)

Please describe your patient's functional ability:

Based on your clinical findings and observations, please describe your patient's current cognitive and/or physical restrictions and limitations:

Please indicate how long these restrictions and limitations should be in place: _____

Homewood
Health | Santé

Name (Last, First)									
Case Number									
DOB (mm,dd,yyyy)									

"The CMA recognizes the importance of a patient returning to all possible functional activities relevant to his or her life as soon as possible after an injury or illness. Prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical and social well-being. A safe and timely return to work benefits the patient/employee and his or her family by enhancing recovery and reducing disability." -- 2013 Canadian Medical Association Policy Statement

Please indicate the date your patient should be ready to return to some form of work, bearing in mind that restrictions or limitations could be accommodated:_____

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period:

Note to Physician:
The information in this statement will be kept in a disability benefits file at Homewood Health and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Please affix office stamp or complete the following:

Name of Attending Physician: (please print)	Physician's Specialty:	Telephone Number:
Address:		Fax Number:
Signature:		Date: (mm/dd/yyyy)

Thank you for your assistance.
Please send the completed form to Homewood Health via confidential fax at 1-888-429-1747

For assistance with this form, please contact Homewood Health Inc. at disabilitymanagement@homewoodhealth.com