

# Attending Physician's Statement Psychological Disability

Employee's name \_\_\_\_\_

McGill ID # \_\_\_\_\_

I authorize the release of any information with respect to this claim to my employer and/or his representative.

Employee's signature \_\_\_\_\_

Date \_\_\_\_\_

*To the Attending Physician,*

*As a permanent employee of McGill University, your patient is eligible for salary continuance in the case of short term disability. McGill University manages its own short term disability plan. Please provide the following medical information to allow us to review your patient's eligibility for salary continuance.*

**DE** (To be completed by the attending physician) **DE**

## Diagnosis

Diagnosis (as per the DSM V) \_\_\_\_\_

- Personality disorders \_\_\_\_\_

- General medical conditions \_\_\_\_\_

- Psychosocial or environmental problems (triggers) \_\_\_\_\_

- GAF Score \_\_\_\_\_

Symptoms: \_\_\_\_\_

Functional limitations preventing the patient from working : \_\_\_\_\_

## Treatments

Medication (and dosage): \_\_\_\_\_

Referral made to:  psychiatrist  psychologist  social worker  EAP  other \_\_\_\_\_

Specialist's name and frequency of visits \_\_\_\_\_

Evolution of condition:  Progression  Regression  Stabilization Prognosis \_\_\_\_\_

Patient's co-operation in treatment:  high  medium  low

Date of visit \_\_\_\_\_ Date of next visit \_\_\_\_\_

## Return to Work

Anticipated return to work date: \_\_\_\_\_

*A progressive return to work may be favorable to your patient. Please note that McGill University is committed to providing accommodation whenever possible.*

Restrictions: \_\_\_\_\_

Progressive return to work schedule: \_\_\_\_\_

**DE** **DE**  
Name \_\_\_\_\_ License # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address, phone #, and fax #, or clinic stamp

*The employee is responsible for the completion of this form without expense to the University.*