MANITOBA MUNICIPAL EMPLOYEES DISABILITY INCOME PLAN

PHYSICIAN'S REPORT

Note to Physician: Please complete this form to the best of your knowledge and **attach copies of reports and results you believe to be relevant to this case.** Forward completed form to:

The Municipal Employees Benefits Program, PO Box 764, Winnipeg, MB R3C 2L4
Fax (204) 943-5998 Phone (204)926-7979 or Toll Free 1-800-432-1908

The fee for completion of this report is the responsibility of the applicant/patient.

APPLICANT/PATIENT	PHYSICIAN
Name: _____	Dr. _____
Address: _____	Address: _____
_____	_____
Date of Birth: _____	Phone No: _____

1. Are you the patient's regular family physician? ☐ Yes ☐ No

2. a) How long has this patient been under your care? _____

   b) On what date did you first see this patient regarding this disabling medical condition?_____

3. On what date did this medical condition cause the applicant to be unable to work?

   _____

4. From what medical condition(s) does the applicant suffer, such that, in your opinion, does this patient require the support of total or partial disability benefits at this time?

   _____

   _____

5. Please highlight your patient's relevant subjective medical concerns at this time.

   _____

   _____

   _____

6. a) Please review the objective medical findings to support your patient's current diagnosis. Include height, weight, BP, ROM of affected joints, neurological findings, etc.

   _____

   _____

   _____

   _____

   Height: _____ Weight: _____ Blood Pressure: _____

   b) On what date were these examination findings based? _____

7. What form of investigations and/or medical consultations has Mr./Ms_____ undergone to date? Please attach copies of reports and results you believe to be relevant to our current review of this case.

8. a) Which, if any, medical tests / consultations are still pending?

   b) Please provide dates for same, if available.

9. What form of treatment is/has the patient undergone for their medical condition?

   a) Has this treatment been completed? ☐Yes ☐No

   b) If yes, when was it completed? _____

   c) If not, what treatment is still pending and have dates been established for the pending treatment(s)?

   d) What, if any, side effects is the patient experiencing as a result of their treatment(s)?

   e) Do any of these pose a safety hazard should this patient return to work?
   ☐Yes ☐No If so, please elaborate in as much detail as possible.

10. Are you aware of any psychosocial, situational or workplace factors impacting upon the patient's current medical condition. ☐Yes ☐No
    If so, please elaborate in as much detail as possible.

11. a) What is Mr./ Ms _____'s current medical impairment(s) at this time? Please outline the impairment(s) for each active and current diagnosis.

b) In your opinion, how do these impairments translate into any physical or psychological restrictions or limitations? Please outline your estimation of the patient's current restrictions / limitations and functional abilities.

c) What is the anticipated duration for the above outlined restrictions/limitations?

d) In your opinion, are any of these limitations/restrictions to be considered permanent?
☐ Yes ☐ No
If so, please outline reasons for same. If not, when should they be reassessed?

12. At this point, in your opinion, is this patient capable of:

a) returning to the full work capacity of his/her own job ☐ Yes ☐ No
If not, please explain or suggest any minor modifications which you feel would help your patient to remain at work (i.e. sit stand-stool, time off for doctors appointments, etc)

b) a graduated return to work in his/her own job ☐ Yes ☐ No
If not, please explain

c) suitable short-term modified duties in keeping with the restrictions outlined for the patient?
☐ Yes ☐ No If not, please explain

Date

Physician's Signature