Health Shared Services Saskatchewan - 3sHealth
Employee Benefits
700-2002 Victoria Ave
Regina, SK S4P 0R7
T. 306-347-5559 F. 306-347-5910
Toll Free: 1-866-278-2301

Attending Physician's Initial Statement
Disability Income Plan Benefits

PATIENT AUTHORIZATION

I authorize all physicians and medical practitioners involved in the assessment, investigation and treatment of the medical condition(s) affecting my absence from work to provide 3sHealth with the information required for my 3sHealth Disability Income Plan Benefits application.

Signature ______________________________ Date ___/___/___ (dd / mm / yy)

Name (please print) ______________________________ Date of Birth ___/___/___ (dd / mm / yy)

NOTES TO THE PHYSICIAN

This form is designed to help compile the information necessary to determine your patient's eligibility for 3sHealth Disability Income Plan Benefits. It is important that these questions be answered comprehensively in order to accurately determine eligibility for benefits and, if the patient is eligible, to effectively manage his/her absence from and return to work. Incomplete information could result in difficulty determining your patient's eligibility for benefits and necessitate further enquiry.

PLEASE NOTE THAT 3sHealth WILL NOT COVER COSTS ASSOCIATED WITH THE COMPLETION OF THIS FORM AS IT IS YOUR PATIENT'S RESPONSIBILITY TO FURNISH EVIDENCE OF TOTAL DISABILITY.

It is important that your patient apply for the appropriate type of wage replacement benefit. Some employers are not aware of the cause of their employee's illness or injury. If you believe that your patient's medical condition has arisen as a direct result of employment, the patient should be advised to consult his/her employer about an application for ***Workers' Compensation Board*** benefits before proceeding with this application to 3sHealth.

TO BE COMPLETED BY THE PHYSICIAN

Diagnosis(es) of the medical condition(s) primarily affecting your patient's ability to perform his/her occupation:

Primary:

Secondary:

Please provide the date that you recommended your patient stop working due to this medical condition:

What are the reasons for your recommendation that your patient cease working?

Please list the dates that your patient consulted you regarding this medical condition, and the names and dates related to consultations with other physicians or specialists regarding this diagnosis:

Has your patient had this or any related medical condition prior to the current absence from work? ☐ No ☐ Yes

If yes, please provide the dates of consultations with yourself or any other physicians to the best of your knowledge:

Please describe your patient's subjective symptoms:

Please indicate your patient's objective findings:

If relevant to diagnosis(es), please indicate patient's: Height _________ Weight _________ BP _________ Pulse _________

Continued

We require that you attach copies of all completed medical investigations and test results. Are additional medical investigations being arranged? Please provide dates.

Please describe the current treatment program including the following (if applicable):

Names and dosages of medications: ____

Details regarding concurrent treatments (e.g.: physiotherapy, counseling, etc.): ________________________________

Date and type of surgery: ____

Hospital admission/discharge dates: ____

Future plans for treatment: ____

3sHealth can provide vocational rehabilitation services to assist disabled members in returning to the work force. Do you have any recommendations that may assist the vocational rehabilitation coordinator in helping your patient to successfully return to work following his/her recovery from the acute phase of this medical condition? Please be specific with regard to dates, duration, and modifications to job or schedule:

We realize that predicting the length of recovery from medical conditions is difficult; however it is important that we have a clear understanding of the length of absence which is expected. Please provide the date you anticipate that your patient will be able to return to work or the length of time expected for recovery:

If you are unable to provide an estimated date of recovery, please indicate the date you will be re-assessing your patient:

If condition is related to pregnancy, please indicate the expected date of delivery:

In the space below, feel free to provide any other information which may be relevant to your patient’s medical condition and absence from work. Please be sure to indicate other medical conditions, complications, or non-medical factors which may prolong your patient’s absence from work:

Thank you for your assistance with this application process and management of your patient's absence from work.

____ Date ____/____/____ (dd / mm / yy)

Signature

Please legibly print, type or stamp your name, address and specialty:

Tel: ____________________

Fax: ____________________

E-Mail: ____________________

3sHealth Employee Benefits is committed to protecting the privacy of your personal information. We collect and use your personal information to determine your eligibility for coverage and to administer the benefit plans. We limit access to your personal information to 3sHealth Employee Benefits staff, to any third party authorized by 3sHealth who requires it to administer your benefits, to persons to whom you have granted access, and to persons authorized by law.