Dear Colleague,

I am writing to you on behalf of 3sHealth Employee Benefits in my capacity as consulting physician.

When healthcare system employees have an illness or injury that may impact their ability to work, they can apply for income and support from the Disability Income Plans administered by 3sHealth. The plans cover both In-Scope (union) and Out-of-Scope (non-union) employees. Employees are covered by specific plans which may differ depending on their union affiliation or Out-of-Scope status. However, the goal of all the plans is to ensure your patients receive appropriate treatment and accommodations that return them to functionality and gainful employment.

As a physician or nurse practioner, you can help achieve this outcome in an important way. Your role as the attending physician or nurse practioner supports your patient through the process and allows them to successfully return to work whenever possible.

I hope this package of information will help you and your patient navigate the Disability Income Plan claim process successfully.

Enclosed in this package:

1. **Attending Physician's Initial Statement**
   This document supports the employee's application for disability benefits. It requires a disabling diagnosis and any co-morbid conditions which may impact recovery and return to function. It also requests information with respect to subjective symptoms and objective findings and a treatment plan, including further consultations or diagnostics planned or in progress. We ask that your comments also include your patient's work restrictions and limitations. It is most helpful when this information is fully documented and legibile to allow for timely adjudication of the file.

It is helpful to remember that this form should be completed in keeping with the College of Physicians and Surgeons of Saskatchewan Policy on the Role of Physicians in Certifying Illness and/or Assessing Capacity for Work.

As the attending physician or nurse practioner, do you support work accommodation?
This is a frequent and important question. Reasonable accommodations are adjustments or modifications provided by an employer to enable people with disabilities to enjoy equal employment opportunities. A gradual return to work program can also be used to assist a patient to return to the workplace by an increase in hours and/or duties with the ideal to safely return the patient to their pre-disability level of work. Other questions, including whether you support work accommodation rather than disability leave and whether you support a graduated return to work, can impact the length of time it takes for your patient to return to work. Please note that all health system employers are encouraged to explore work modification and work accommodation for their employees. We believe that keeping the employee engaged in the workplace as their medical needs are addressed can provide a positive return to work experience for the patient when appropriate, without harm and without jeopardizing their safe return to work.

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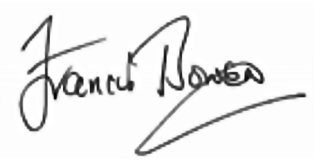
The Disability Income Plan administered by 3sHealth were formulated by all health system employers and the unions representing health system employees. The role of 3sHealth staff is to provide information and to process the claims according to the guidelines set out in the agreed upon plan policies and procedures. Requirements, such as the patient obligation to pay for reports, have been negotiated and agreed upon by a wide group of stakeholders, including employee representatives.

The role of medical consultants to 3sHealth is to review the medical information gathered and ensure the reported diagnosis, treatment plan and prognosis, as provided by you, the attending physician, fits with the objective information. If you are expecting variances from the typical recovery period for the stated diagnosis we can provide context or suggest what further information may be required to adjudicate the file.

If you have specific concerns or questions, please do not hesitate to contact us directly at any time.

Sincerely,



Dr. F. Bowen
Medical Consultant, Disability Income Plan

To be provided to your physician or nurse practioner with the Attending Physicians Initial Statement.

3sHealth
better together

We've made it easier

You can now quickly dictate your report instead of completing this form by hand

You can easily download the "Attending Physician's Initial Statement" form in both the Accuro and Med Access electronic medical records. Or, follow the instructions below to log in with your existing provincial dictation User ID Number. Once transcribed, a copy will automatically be returned to you for your files. **If you do not have a provincial dictation User ID Number, or require assistance, please email transcription@3shealth.ca and we can get you setup with your free ID.**

To do so, simply follow these instructions.

1. Dial 1-844-666-3250
2. Follow the three prompts:
   - Input your **User ID Number**
   - Enter **Site Location Number**..... 5
   - Repeat **User ID Number** (for security).
3. Enter the **Work Type Number**,
   - Attending Physician Statement 1
   - Request for Additional Medical Information 2

   followed by the **# key**.
4. Prompt will ask for chart number, **press # key** to bypass
5. After the tone, **begin dictation**. Every time you dictate, please state:
   - 5.1 This is **(your first and last name)**,
   - 5.2 Dictating a **(work type)**,
   - 5.3 For patient **first** and **last name (please spell names)**,
   - 5.4 Health Services Number **(HSN)** is,
   - 5.5 Date of birth,
   - 5.6 Seen on **(date of care event)**.
6. **Follow the headings on the provided form and dictate for each one.**
7. **Press 5** to end dictation session and disconnect.

Other Keypad functions to use while dictating:

- **1** – Play
- **2** – Start or Record/Pause/Restart
- **3** – Rewind and Play Back
- **4** – Fast Forward
  - **44** – Go to End of Job
- **5** – Disconnect
- **6** – Stat*
- **7** – Rewind
  - **77** – Go to Beginning of Job
- **8** – End of Current Job/Begin New Job (will act as a pause)
- **##** – Play Job Number

The patient is responsible for any fees related to the completion of this form.

Initial Disability Insurance Medical Statement

Section 1 — Patient Information and Consent
TO BE COMPLETED BY THE PATIENT

Patient Name (Last, First, Middle Initial)	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd/mm/yyyy)

Date Last Worked
(dd/mm/yyyy) _____

Date Returned to Work or Expected Return to Work Date
(dd/mm/yyyy) _____

Please list your present medications:

	Name of Medication	Dosage (mg)	How Often?
1.			
2.			
3.			
4.			
5.			

Please provide your:

Height: _____

Weight: _____

Dominant Hand:

Left ☐ Right ☐

I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.
I understand that I am responsible for any fees related to the completion of this form. **Medical and health information excludes genetic test results.**

_____ _____
Patient Signature Date of Consent (dd/mm/yyyy)

Section 2 — Medical Statement
TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify)_____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: _____

_____

Secondary and/or Complications: _____

_____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): Vaginal ☐ C-Section ☐

Is this condition due to:

Occupational Illness Yes ☐ No ☐
Occupational Injury Yes ☐ No ☐
Motor vehicle accident Yes ☐ No ☐
Other accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Date of first visit to you pertaining to this condition:
(dd/mm/yyyy) _____

First date of work absence due to condition:
(dd/mm/yyyy) _____

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1)**

_____

_____

_____

_____

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) _____

Date of last visit: (dd/mm/yyyy) _____

Date of next visit: (dd/mm/yyyy)

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐ Unknown ☐

If yes, date: (dd/mm/yyyy) _____ Treatment Provider: _____

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

Please elaborate: _____

Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: _____

_____

_____

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

Did/will the patient have day surgery? Yes ☐ No ☐

Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

- **If your patient has returned to work, or if the duration of their disability will be less than 4 weeks, please stop here and sign the end of the form.**
- **For disabilities expected to be greater than 4 weeks, please complete all pages.**

Investigations

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results**
- **consultation reports**
- **clinical notes**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Restrictions and Limitations

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

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy) _____ Type of license: _____

Is the patient capable of managing their own affairs? Yes ☐ No ☐

Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐

Workplace Issues ☐ Social/Family Issues ☐ Financial/Legal Issues ☐ Personality issues ☐ Addiction ☐ Other ☐

Please elaborate: _____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

Notice to Physician/Medical Provider:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician/Medical Provider (please print)	Specialty and license/registration number	Date Signed (dd/mm/yyyy)

Address (Street, City, Province, Postal Code)	Telephone # (+ area code) Fax # (+ area code) Email address

Signature