SALARY INSURANCE CLAIM FORM IN MENTAL HEALTH

Centre intégré universitaire de santé et de services sociaux du Centre-Ouest-de-l'Île-de-Montréal
Québec

LAST NAME: _____ FIRST NAME: _____
DATE OF BIRTH: _____/_____/_____ EMPLOYEE #: _____ MANAGER'S NAME: _____
PHONE NUMBER: _____ EMPLOYMENT SITE IN CIUSSS: _____

Authorization of the employee **

I hereby declare the following information is accurate and authorize physicians and hospital or clinic representatives to provide my employer with all relevant information pertaining to my disability claim or the period of absence described in this claim.

Signature: _____ Date: _____/_____/_____

I authorize the interveners and the designated physicians of the occupational health and safety service of CIUSSS COÎM as well as the doctor(s) expert(s) to communicate with my doctor(s) Trainer(s), Specialist(s) or Therapist(s) to provide them with any report and / or relevant information pertaining to my disability file or the period of absence described in this claim.

Signature: _____ Date: _____/_____/_____

**** The employee's omission to sign this authorization may result in a delay in the processing of the application.**

GENERAL INFORMATION FOR CLAIMANT AND TREATING PHYSICIAN

DEFINITION OF DISABILITY

TO BE ELIGIBLE FOR SALARY INSURANCE BENEFITS, THE SALARIED EMPLOYEE MUST PROVE THAT HIS OR HER MEDICAL CONDITION MEETS ALL OF THE FOLLOWING CRITERIA:

1. THIS DISABILITY IS THE RESULT OF DISEASE, ACCIDENT, COMPLICATION OF PREGNANCY, OR CONDITION RELATING TO FAMILY PLANNING OR ORGAN OR BONE MARROW DONATION

AND

2. THE SALARIED EMPLOYEE IS RECEIVING MEDICAL ATTENTION FOR THIS DISABILITY

AND

3. THE SALARIED EMPLOYEE IS **TOTALLY UNABLE** TO ACCOMPLISH THE USUAL TASKS REQUIRED IN THE PERFORMANCE OF HIS OR HER DUTIES, OR OF ANY SIMILAR DUTIES OFFERED BY THE EMPLOYER AND INVOLVING EQUIVALENT COMPENSATION.

DISABILITY REHABILITATION OR PROGRESSIVE RETURN TO WORK

AFTER RECEIVING APPROVAL FROM THE APPROPRIATE AUTHORITY AND SUBJECT TO THE PROVISIONS IN COLLECTIVE AGREEMENTS, A SALARIED EMPLOYEE CAN QUALIFY FOR A REHABILITATION PERIOD WHILE CONTINUING TO BE SUBJECT TO THE SALARY INSURANCE PLAN.

Date of onset of disability: _____/_____/_____

Have you completed documents? Yes ☐ No ☐
RRQ ☐ _____/_____/_____ SAAQ ☐ _____/_____/_____ CNESST ☐ _____/_____/_____ IVAC ☐ _____/_____/_____

Multiaxial Diagnosis:
Axe I (psychological diagnostic):_____
Axe II (personality disorders and mental retardation): _____
Axe III (physical disorders): _____
Axe IV (contributing factors): _____
Axe V (Global Assessment of Functioning): _____

Date of onset of symptoms: _____/_____/_____
Triggers: _____
Persistent elements: _____
Is the current disability related to the employee's work? Yes ☐ No ☐ If yes, specify: _____
_____

Intensity of symptomatology according to your overall assessment:

Intermittent ☐ Minor ☐ Moderate ☐ Severe ☐

Evaluation of the symptomatic condition following the first assessment (Check the appropriate box)

Legend : stable state = improvement ↑ deterioration ↓

	= ↓ ↑		= ↓ ↑		= ↓ ↑
Alcohol / substance abuse	☐ ☐ ☐	Fatigue / Insomnia	☐ ☐ ☐	Phobia	☐ ☐ ☐
Psychomotor activation	☐ ☐ ☐	Suicidal ideation	☐ ☐ ☐	Crying / Sadness	☐ ☐ ☐
Anhedonia / Loss of interest	☐ ☐ ☐	Irritability	☐ ☐ ☐	Weight / loss of appetite	☐ ☐ ☐
Anxiety	☐ ☐ ☐	Social isolation	☐ ☐ ☐	Motor slowdown	☐ ☐ ☐
Panic attack	☐ ☐ ☐	Libido	☐ ☐ ☐	Others _____	
Concentration / Memory trouble	☐ ☐ ☐	Obsessions / Compulsions	☐ ☐ ☐	_____	

Treatment :

Hospitalisation	From: _____/_____/_____	To : _____/_____/_____
Day centre	Start date: _____/_____/_____	Frequency: _____
Pharmacotherapy	Specify: _____	Posology: _____
	Specify: _____	Posology: _____
	Specify: _____	Posology: _____
Psychotherapy:	Start date: _____/_____/_____	Frequency: _____
Type of therapy:	_____	Planned consultation: _____/_____/_____

Return to Work Plan:

☐ Return to regular work Date: _____/_____/_____

Rehabilitation period: Starting the: _____/_____/_____

- ☐ Return to progressive work in their usual functions
- ☐ Return to work with light duties

Medical return conditions and / or restrictions:

_____

_____

Anticipated date of return to work: _____/_____/_____ Date of the next medical appointment: _____/_____/_____

What are the objective medical reasons for extending the disability?

_____

_____

Do you have any specific recommendations that can facilitate a return to work?

_____

_____

Doctor's identification

NAME OF PHYSICIAN (in print): _____ License number: _____

Physician's specialty: _____

Phone Number: _____ Fax Number: _____

Signature of the doctor (stamp not accepted)_____ Date : _____/_____/_____