Allendale Centre East
Suite 301, 6104-104 Street NW
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Phone: 1-877-431-4786
www.asebp.ca

ATTENDING PHYSICIAN'S STATEMENT

SHORT-TERM DISABILITY MANAGEMENT (STDM) PROGRAM

INSTRUCTIONS

Please note that the patient is responsible for the costs associated with completion of this form.

1. Complete this form in full by either filling it out electronically and providing a digital signature as outlined below, or by printing and signing a hard copy.
2. **Answer all questions fully and indicate when information is not applicable, not available, or not known.**
3. Send the completed form to ASEBP by faxing 780-438-5304 or emailing ShortTermDisability@asebp.ca.

A. ATTENDING PHYSICIAN'S STATEMENT

Name of patient *(please print)*: Patient's date of birth: (YYY/MM/DD)

Diagnosis

Primary:

Secondary:

If pregnancy related, expected date of delivery: (dd-mm-yyyy)

Vaginal: ☐ C-Section: ☐

Occupational illness/injury: Is condition arising from employment? ☐ Yes ☐ No Has a WCB claim been submitted? (if applicable) ☐ Yes ☐ No

Description of current symptoms including severity and frequency:

Date symptoms first appeared/occurred (dd-mm-yyyy): First date of work absence due to condition (dd-mm-yyyy):

Date last seen (dd-mm-yyyy): Date of next appointment (dd-mm-yyyy):

Treatment (medications, dosage, physiotherapy, psychotherapy, other):

Has the patient been treated for this condition in the past? ☐ Yes ☐ No If yes, date(s) (dd-mm-yyyy): _____

To your knowledge, is the patient following the recommended treatment program? ☐ Yes ☐ No

Hospitalization

Has the patient been hospitalized ☐ Yes ☐ No Date admitted (dd-mm-yyyy): _____

Name of institution: _____

If surgery was performed, please provide:

Date (dd-mm-yyyy): Description of surgery:

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)
- Consultation reports

Are tests/investigations pending? ☐ Yes ☐ No If yes, expected date of receipt (dd-mm-yyyy): _____

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist: _____ Specialty: _____ Date of visit (dd-mm-yyyy): _____

B. PROGNOSIS AND RETURN TO WORK

Is the patient capable of returning to work in any capacity now? ☐ Yes ☐ No When can the patient start a **modified** return to work:_____

Anticipated date when the patient can return to work **regular** duties and hours (without medical restrictions):

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

C. ADDITIONAL REMARKS

Please provide any additional comments or recommendations:

D. ATTENDING PHYSICIAN INFORMATION

Name		Phone (include area code)
Street address		Fax
City/town	Province	Postal code
Signature		Date (dd-mm-yyyy)

Please return this form to:

Alberta School Employee Benefit Plan **Fax: 780-438-5304**