Practitioner's Assessment Form

To the Practitioner

The purpose of this form:

1. To enable the Occupational Health professional to assess the Team Member's fitness for work or level of disability.

2. To ensure your patient's claim for disability benefit receives proper consideration.

As the treating practitioner, you play a major role in this process by defining as accurately as possible, the Team Member's capabilities, limitations and progress in rehabilitation. It is to be filled out by the treating practitioner and returned to the Corporate Health Services Department.

Mail original form to:

Team Members residing in Québec	**TELUS Mobility and TELUS Communications Inc (excluding team members residing in Quebec)**
Service de santé TSSI 1, rue Jules. A. - Brillant Département R0124 Rimouski, Québec G5L 7E4	TSSI Health Services 12th floor, 3777 Kingsway Burnaby, BC V5H 3Z7
Telephone: 1 877 720 5358 Toll Free Fax: 1 877 722 2817	Fax: 604 432 9456 Toll Free Fax: 1 877 432 9456

PAF PAYMENT

Invoice Information:

Team Members are responsible for direct paying the Practitioner for completion of this form. Team Members can submit the receipt (indicating completion of PAF 10053 form) to their TELUS Extended Health Benefit Plan at Sun Life.

To the Team Member

This confidential form is to be completed by your treating practitioner and returned only to the Corporate Health Services Department.

Confidential

"Important information about your Short Term Disability Benefits"

Short term disability payments will be made available when a team member:

- has applied for STD by completing the required medical forms following an absence of 10 consecutive days, and when the medical documentation substantiates the disability absence duration, and aligns with disability best practices. All medical documentation must be received in Health Services by specified dates or benefit payments will be jeopardized.
- has signed appropriate medical consents.
- is under the regular care of a licensed physician, and follows recommended treatment / rehabilitative plans as outlined.
- maintains regular and open communication with their manager and Health Services.
- provides additional medical documentation, by specified dates, as requested by Health Services.
- actively participates in all appropriate medical, rehabilitative, return to work and assessment processes.
- consults with a third party physician, appointed by the company, if required.
- where possible, schedules medical / rehab activities so that they do not interfere with scheduled work.
- obtains prior approval from Health Services to travel out of town or country. Travel cannot interfere with recovery or treatment schedule.

Disclaimer: This summary contains an overview and general information about the conditions under which short term disability payments will be made under the terms of the Short Term Disability Plans at TELUS. The comments contained herein are not intended to address the specific circumstances of any particular team member or to exhaustively enumerate the eligibility criteria for entitlement to short term disability payments. Should there be a discrepancy between this summary document and the Short Term Disability Plan, the terms of the policy shall prevail.

TELUS

Confidential

PRACTITIONER'S ASSESSMENT FORM

Part 1 - TEAM MEMBER INFORMATION — To be completed by the Team Member's Manager

Team Member Surname	First Name	Employee I.D. No.	Seniority Date (Year Month Day)	Tel. No. (Res.)

Job Status	Job Type	Job Title
☐ FT ☐ PT ☐ JS ☐ Occasional ☐ Temporary	☐ Bargaining Unit ☐ Management	

Date Absence Started	Department	Business Unit	Supervisor's Name	Supervisor's Tel. No.

Part 2 - Authorization to Release Information — To be completed by the Team Member

I authorize the Practitioner identified below to release information about me that is relevant for the purpose of considering my eligibility for benefits and to establish my fitness for work and/or level of disability. This form may be released to TELUS Health Services situated in any province of Canada. I also authorized TELUS Health Services to contact the practitioner in writing for any additional relevant information that they may require for this purpose, provided a copy of the information request is sent at the same time to myself. It is understood that health information received by the TELUS Health Services department will be kept in strict confidence. These consents are valid for six months or until I return to full time employment, whichever event shall first occur, unless I revoke them in writing.

Team Member's Signature _____ Witness _____ Year Month Day

Part 3 — To be completed by the Team Member's Practitioner

Date of First Visit Year Month Day Date of Last Visit Year Month Day

☐ Is this an Illness? ☐ Injury? Did this illness/injury occur: ☐ On the job? ☐ Off the job? ☐ MVA?

Team Member is being followed up: Weekly _____ Monthly _____ Other _____

MEDICAL CONDITION

1. (a) Diagnosis: _____

_____

_____

(b) if providing a psychological Diagnosis please complete DMS IV _____

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: GAF: _____

Other diagnostic tools relied upon but only if relevant: _____

2. Describe the signs and symptoms of the illness/injury of the Team Member. _____

_____

_____

_____

Is this absence related to pregnancy? EDD Year Month Day

Team Member Surname	First Name	Employee I.D. No.	Seniority Date (Year Month Day)	Tel. No. (Res.)

TREATMENT

3. List medications (if relevant): _____

4. a) Describe active treatment (eg: physiotherapy, chiropractic, counseling, etc.) including frequency and duration, other rehabilitation and any surgical interventions and/or hospitalizations including dates. _____

b) List other practitioners involved in the assessment and/or care of this Team Member. _____

5. Outline any further treatment interventions, investigations, or referrals. _____

REHABILITATION

6. Describe the functional limitations that are impacting the Team Member's ability to work. _____

7. What is the prognosis of the Team Member's illness/injury **with regards to return to work**? _____

8. In my opinion this Team Member is: (Modified/Alternate duties are available within the company)

☐ Fit to Return to Work, regular duties, full time, as of: Year Month Day

☐ Fit to Return to Work as of: Year Month Day

- ☐ Modified duties with the limitations outlined in #6.
- ☐ Modified hours Expected duration of limitations _____ days _____ weeks.

☐ Unfit for Work:

- ☐ Temporary: Expected return to work date Year Month Day
- ☐ Permanently

9. Any other relevant medical information that would assist us in the review of this case.

_____

_____

_____

_____

10. Practitioner's Name (print) _____

Area of Practice/Specialty Address _____ Postal Code _____

Phone Number _____ Fax Number _____

Signature _____

This is a confidential form and is to be returned only to the Corporate Health Services Department. When faxed please forward the original copy by mail. Thank You