DS2444B — The Medical Report: A Completion Guide

A clinical, question-by-question guide for the health professional completing the disability medical report, with fill-in templates keyed to the eligibility test. Updated July 2026.

Before you use any template on these pages

Every template here is scaffolding, to be completed to the **true clinical picture** and no further. Delete any clause that does not fit this patient.

Accuracy is the strongest position and the one that withstands review. An overstated report can be challenged and can cost a patient the case they truly have.

Your signature certifies your clinical opinion. These templates exist to put your real findings into the language the determination weighs — not to supply findings you did not make.

For the completing health professional

This is a shorthand guide to the DIA Medical Report (DS2444B). It maps each field to what the adjudication turns on, and offers fill-in templates keyed to the eligibility test. The official form is at open.alberta.ca.

The test the report must speak to

AISH eligibility: a severe and permanent impairment that substantially limits the ability to earn a livelihood. Document the limitation and its permanence — not the accommodations that would let the patient work.

The accommodation trap — the single most important framing

"Accommodation" language reads as *capable with support*, which is the ADAP finding, not the AISH one. Where clinically true, state that **no accommodation renders competitive employment reliable or sustainable.** Unpredictability and inability to self-sustain are often the strongest findings: an employer can adapt a workstation; none can adapt to unpredictable incapacity.

Relationship With Applicant (Q1–Q4)

Q1: confirm Alberta registration; give discipline and registration number. Q2–Q4: treating duration, last contact, and frequency. Longer, regular treating relationships carry evidentiary weight — state them plainly (e.g., "primary provider since [yyyy], reviewed [monthly]"). A specialist seeing the patient episodically should say so; it frames the scope of the opinion.

Diagnosis and Medical History (Q5–Q10)

Q5. Diagnoses + codes + onset. List all conditions, primary and secondary, with codes and onset dates. Early or congenital onset dates support permanence — record them precisely. Include comorbidities that compound function even if individually sub-severe; the cumulative picture is what is adjudicated.

Q6. Diagnosis detail + specific symptoms. Etiology, classification, stage/grade, and the specific symptoms per diagnosis.

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[Condition] — [etiology/classification]. Symptoms this patient experiences: [list].
Functional consequence: [what the symptoms prevent — e.g., sustained concentration,
reliable attendance, self-initiation of tasks]. Onset [mm-yyyy]; course [static /
progressive / relapsing].
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Q7. Medical history + chronology. This is the central narrative field. Tie each condition to a duration and a functional restriction, and close on permanence and impact on earning capacity.

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[Patient] has a [X]-year documented history of [condition(s)], first presenting
[mm-yyyy], with [stable / progressive] course despite [treatments tried]. The
impairment restricts [functions]. These restrictions are [continuous / unpredictable
and recurrent] and are not resolved by workplace accommodation, because [reason — e.g.,
the limiting factor is unpredictable incapacity, not the work environment]. In my
opinion the condition substantially limits this patient's ability to earn a livelihood
on a reliable, sustained basis.
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Q8–Q10. Referrals, evidence, admissions. List specialist consultations and attach reports; attach diagnostics, imaging, labs; list relevant hospital admissions with dates and reasons. Attaching documents pre-empts a later request for further information.

Degree of Impairment — Activities of Daily Living (Q11–Q40)

Rate each item to the true clinical picture: 0 none, 1 mild, 2 moderate, 3 severe/unable. Do not under-rate to appear conservative — an accurate 2 or 3, with a one-line note in the describe column, carries the file.

> **Note variability — do not average it away**
> Adjudication weighs cumulative burden across domains. Complete the describe box wherever a rating is 2 or 3. For episodic and fluctuating conditions, write the range, not the mean: *"3 on flare days, 1 between"* — not a blended "2."
> The government's own guide acknowledges that recurring conditions can cumulatively amount to severe disability. A good day is not the measure; the pattern is. Averaging erases exactly the evidence that matters.

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Q40 — Across mobility, cognition, personal care, and independent living, this patient's
cumulative impairment is [moderate–severe]. Key drivers: [items rated 2–3]. On [flare /
bad] days, [patient] requires [assistance/supervision] for [tasks]. The combined effect
is that [patient] cannot independently maintain the routine and reliability that
sustained employment requires.
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Level of Impairment — Mental Health / IEWS (Q41–Q68)

Same rating discipline (0–3) across mood, thought/perception, cognition, behaviour, orientation, speech, somatic, and safety. Fields that most often carry these files: Q50–52 attention / concentration / comprehension; Q53 executive function (self-regulation, planning, organization) — pivotal for acquired brain injury and neurodevelopmental profiles; Q57 memory (specify long / short / working); Q60 amotivation, Q59 impulse control, Q43 emotional dysregulation — describe the functional cost. Q67 (suicidality) is a clinical safety field; complete it from your assessment as you would any risk documentation.

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Q68 — Cumulative mental-health impairment is [moderate–severe], driven by [items rated
2–3]. [Executive dysfunction / cognitive deficits / mood instability] mean [patient]
cannot reliably [initiate and sequence tasks / sustain attention / regulate under
ordinary workplace demand] without continuous external structure. These deficits are
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[longstanding / organic] and persist [despite treatment]. They are not correctable by
accommodation, as they affect the capacity to self-organize and self-sustain that any
employment presupposes.
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Remedial Therapy (Q69–Q74) — the permanence gate

Denials often turn on the theory that more therapy might improve the condition, so it is not yet "permanent." Answer these fields so the record closes that gate where it is clinically closed: treatments tried and exhausted, and why further treatment is not expected to restore work capacity. If a treatment is nominally available but inaccessible in a clinically relevant timeframe (waitlist of [12–16+ months]), say so — it is not meaningfully available.

Q69–Q70. Medications and their functional effect (including sedation or cognitive side effects that themselves limit work); treatment history with timeframes and outcomes.

Q71. Current plan, when initiated, review frequency — or, if options are exhausted, say so explicitly.

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Q71 — Current management: [plan], initiated [mm-yyyy], reviewed [interval]. Available
interventions have been [tried / exhausted] with [partial / no] functional gain.
[Remaining options are limited to symptom management, not restoration of work capacity.
/ Further options are inaccessible within a clinically relevant timeframe: [waitlist /
access barrier].]
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Q72–Q73. Compliance. Answer truthfully. An unexplained "non-compliant" can sink an otherwise strong file. Legitimate reasons belong on the record.

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Q72–73 — Adherence is limited by [cost / side-effect intolerance / access / the
disability itself — e.g., executive dysfunction impairing medication management]. This
is a consequence of the condition and circumstances, not refusal of care.
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Q74. Further treatment anticipated? If it is not expected to restore the capacity for sustained work, state that plainly.

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Q74 — No further treatment is anticipated that would be expected to restore this
patient's capacity for reliable, sustained employment. Management is directed at
[symptom control / stability], not functional recovery.
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Prognosis (Q75) — the determinative field

Four options: Temporary, Episodic, Permanent, Undetermined. Where clinically supported, **Permanent — not expected to change or improve over time with treatment** is the finding the AISH determination rests on. For episodic conditions, use **Episodic** and quantify frequency, length, severity, and total duration — unpredictable recurrence is itself a barrier to employment. Avoid "Undetermined" if the record supports permanence; an ambiguous prognosis defaults the file toward the lower program.

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Q75 — Permanent. [Condition(s)] are longstanding and not expected to improve with
further treatment. Prognosis for return to reliable, sustained employment is poor. [For
episodic: episodes occur [frequency], last [duration], severity [level], onset
unpredictable; between episodes the patient [residual limitation].]
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Additional Comments (Q76) — the closing synthesis

Draw the domains together into one statement of cumulative impairment, permanence, and impact on the ability to earn a livelihood.

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Q76 — In summary, [patient] lives with [severe and permanent condition(s)] producing
cumulative impairment across [physical / cognitive / mental-health] domains. The
limitations are [continuous / unpredictable], not correctable by workplace
accommodation, and not expected to improve with treatment. In my clinical opinion,
[patient] is substantially limited in the ability to earn a livelihood on any reliable,
sustained basis.
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Records to Draw On, and Certification

Netcare is not the full record. Alberta Netcare holds labs, imaging, dispensed medications, and hospital records — not community clinic office notes. Where relevant history sits outside Netcare, draw on the clinic chart, pharmacy record, and specialist correspondence so the report is complete rather than partial.

Certification. Completing the report certifies it contains your clinical findings and medical opinion. Provide name, CPSA/CRNA number, contact details, date, and signature.

Disability Income Assistance – Medical Report

Form DS2444B · Rev. 2026-07 · Protected B (when completed)

Accessibility note: This is a fillable working copy that captures everything the official DS2444B asks. It opens and fills on any phone, tablet, or computer. It is NOT an official Government of Alberta form. The official version is available from the Government of Alberta at open.alberta.ca.

*** (Mandatory) = answer required to achieve application completion.**

Applicant Information

First name *

Middle name

Last name *

Last name on birth certificate (if different)

Other Preferred First name

Date of birth *
Day Month Year

Gender *
Male Female Gender diverse Prefer not to say

Alberta Personal Health Number

Home Phone *

Other Phone (if applicable)

Relationship with Applicant

1. The DIA Medical Report must be completed by a health professional registered in Alberta. Are you a health professional registered in Alberta? *

Yes No

If yes, please provide discipline type

Registration Number

2. How long have you been treating the applicant? *

3. When did you last treat the applicant? * (dd-mm-yyyy)

4. On average, how often do you see the applicant?

Once per week Once every two weeks Once every month More than once every month

Diagnosis(es) and Medical History

5. Specify diagnosis(es) and the DIA Medical Code(s) and/or DSM V Code(s). * (Note: attach relevant medical assessments and reports. A DIA Medical Codes reference chart is provided in the official form.)

Medical condition(s)	Date of onset (mm-yyyy) *	DIA Medical or DSM Code *

6. Provide details about the diagnosis(es) (e.g. relevant etiology, classification, stage/grade/type of disease/illness). Include the specific symptoms the applicant experiences with each diagnosis.

7. Describe the medical history relevant to the condition(s)/diagnosis(es), including chronology of presenting symptoms and progression, if any. Delineate impairment, duration, and restriction associated with each condition. *

Are documents supporting the above attached?

Yes No

If no, please explain

8. Has this person been referred for further medical assessment? *

Yes No

If yes, list consultations and provide consultation reports.

Specialist name	Specialty	Date Last Seen	Report attached
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

9. Is there other supporting medical evidence for the condition(s)/diagnosis(es) (e.g. diagnostic reports, investigations, and laboratory tests)? *

Yes No

Are documents attached?

Yes No

If no, please explain

10. Admission to hospital(s) or other treatment facilities relevant to the medical condition.

Admission (dd-mm-yyyy)	Reason	Discharge (dd-mm-yyyy)	Docs attached
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Degree of Impairment – Activities of Daily Living

To what degree can this person complete the following Activities of Daily Living? *

Rating scale: DK = Don't know 0 = No limitation 1 = Mild (minor assistance / extra time) 2 = Moderate (needs support / some supervision) 3 = Severe (unable; done by someone else).

	DK	0	1	2	3	*Describe limitation, if needed*
Mobility						

	DK	0	1	2	3	*Describe limitation, if needed*
11. Transferring: in and out of bed; on and off toilet						
12. Mobility: walking, getting around						
13. Physical activity: ability to participate in sustained activities and physical strength commensurate with person's age						
14. Sitting						
15. Standing						
16. Stair climbing						
Cognitive Function						
17. Reading						
18. Writing						
19. Understanding or following simple instructions						
Personal Care						
20. Bathing and self-cleaning						
21. Bladder control						
22. Bowel control						
23. Grooming (hair, face, teeth, hands and nails)						
24. Dressing (including buttons, clasps, zips, shoelaces)						
25. Select clothes for weather and situation						
Independent Living Skills						
26. Meal Preparation						
27. Eating: using utensils						
28. Shopping for groceries						
29. Housekeeping						
30. Laundry						
31. Transportation: ability to use available means of transportation						
Social Function						
32. Attending medical appointments						
33. Managing finances: ability to manage own money						
34. Managing prescription medication (if applicable)						
35. Managing Over-the-Counter medication (if applicable)						

	DK	0	1	2	3	*Describe limitation, if needed*
36. Communication using phone, text, email, etc.						
37. Safety: ability to maintain personal safety						
38. Social interactions (get along with others, maintains social boundaries)						
39. Hobbies/taking part in activities for relaxation or pleasure						

40. Using the ratings of the Activities of Daily Living, describe symptoms impacting the cumulative level of an applicant's impairment: *

Level of Impairment – Mental Health (IEWS)

Level of impairment due to mental health aspects. * The checklist below consists of features/symptoms from the Intellectual and Emotional Wellness Scale (IEWS).
Rating scale: DK = Don't know 0 = Not present 1 = Mild (sometimes) 2 = Moderate (often) 3 = Severe (a barrier to well-being).

	DK	0	1	2	3	*Describe limitation, if needed*
Mental and Emotional States						
41. Depressive mood						
42. Euphoria/Elation (elevated mood)						
43. Emotional dysregulation						
44. Anxiety						
Thought and Perception						
45. Delusions						
46. Hallucinations						
47. Thought disorganization						
48. Grandiosity						
49. Dissociative symptoms Increase Decrease						
Cognitive Function						
50. Attention deficit						
51. Concentration deficit						
52. Comprehension deficit						
53. Executive function deficits (e.g., self-regulation, planning and organization)						
54. Insight deficit						
55. Judgement deficit						

	DK	0	1	2	3	*Describe limitation, if needed*
56. Learning deficits (specify)						
57. Memory deficit Long term memory Short term memory Working memory						
Behaviour						
58. Disinhibition						
59. Impulse control deficit						
60. Amotivation						
61. Withdrawn						
Orientation						
62. Disorientation (person, place or time)						
Speech						
63. Speech deficit (not due to language barrier) (specify)						
Physical and Somatic						
64. Appetite change Increase Decrease						
65. Energy change Increase Decrease						
66. Sleep dysfunction Difficulty sleeping Excessive sleeping						
Safety						
67. Suicidality Ideation/Thoughts Plans Attempts						

68. Using the ratings of the Intellectual and Emotional Wellness Scale, describe symptoms impacting the cumulative level of an applicant's impairment: *

Remedial Therapy

69. Complete the chart below or attach a list of relevant medication(s). *

List attached

Type of Medication	Effect on Functioning

70. Describe treatment history and results inclusive of the timeframe. *

71. Describe the current medical plan. Include when treatment was initiated, anticipated results, and how often the plan is reviewed. If no treatment/remedial approaches have been tried or are planned, explain why. *

72. Is the applicant compliant with the treatment plan recommended by their primary health professional? *

Yes No

If no, please explain

73. Is the applicant compliant with a treatment plan recommended by a health professional who is not their primary health professional? *

Yes No

If no, please explain

74. If further treatment is anticipated, describe the treatment and include anticipated results and estimated timeframe. *

Prognosis

75. Duration of the medical condition(s) is likely to be:

Temporary – will improve over time with further treatment.

Estimated duration?

Episodic – episodes recurring as follows:

(Indicate frequency, length of episodes, severity of episodes, and total duration of illness if known.)

Permanent – not expected to change or improve over time with treatment.

Undetermined – unclear whether it will improve over time with further treatment.

Explain

Additional Comments / Information

76. Please include any additional information relevant to the applicant's condition that the ministry should consider in determining eligibility.

Certification

The DIA Medical Report must be completed by a health professional registered in Alberta.

- [ ] I have completed and/or approved the information submitted in this report.
- [ ] This report (and attached documents) contains medical reports, clinical findings and my medical opinion at this time.

Health Professional's name (please print)

Office Address

CPSA or CRNA registration #

Phone

City/town

Province

Postal code

Date (dd-mm-yyyy)

Health Professional's signature