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