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.