



## Medical Report for Canada Pension Plan Disability Benefits

### Instructions for the applicant/patient - please read carefully

An application and a medical report are needed by Service Canada to determine if you qualify for a Canada Pension Plan (CPP) disability benefit.

You (the applicant) must:

- ✓ complete the **Application for Canada Pension Plan Disability Benefits (ISP1151)**. It is available in two formats:

- 📷 **Online:** Go to [www.canada.ca/msca](http://www.canada.ca/msca), or scan:



- ✓ **Paper or fillable form:** Go to [www.canada.ca/esdc-forms](http://www.canada.ca/esdc-forms).

For your safety, visit [www.cyber.gc.ca/en](http://www.cyber.gc.ca/en) for tips on protecting your devices and reporting suspected cyber incidents.

- ✓ fill out **Section 1 and Section 2** of this **Medical Report**.
- ✓ write your **Social Insurance Number** at the top of each page of this **Medical Report**.

Your doctor or nurse practitioner must complete **Sections 3 to 9** of the **Medical Report**, sign it, and send it to Service Canada.

**DO NOT WAIT** for your doctor or nurse practitioner to complete the **Medical Report** before sending your completed application to Service Canada. The date Service Canada receives your application could affect when your benefit starts.

Service Canada will help you pay for the cost of the **Medical Report** by paying up to \$85.00 directly to your doctor or nurse practitioner. Any money owing over this amount is your responsibility.

**Note:** If your doctor or nurse practitioner returns the **Medical Report** to you, you can sign in to your MSCA to upload it, send it to us by mail, or drop it off at a Service Canada office.

### Section 1 - Information about you

Social Insurance Number <b>116 474 248</b>		Preferred language <input checked="" type="radio"/> English <input checked="" type="radio"/> French	FOR OFFICE USE ONLY Date Stamp
Optional: <input checked="" type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Miss <input type="radio"/> Ms.			
First name <b>Oscar</b>	Middle name	Last name(s) <b>Robichaud</b>	
Date of birth (YYYY-MM-DD) <b>1958-11-25</b>	Last name at birth (if different from above)		
Mailing address (No., Street, Apt., PO Box, RR), City/Town, Province/Territory, Country (if not Canada), Postal code <b>203-54 Rue St-Jean Baptiste, Bouctouche N.B.</b>			
Telephone number <b>506-533-6237</b>		Alternate telephone number <b>506-337-4537</b>	
The best time for Service Canada to contact you <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Please don't call, send letters only <b>AFTERNOON</b>			

Service Canada delivers Employment and Social Development Canada programs and services for the Government of Canada

This signed consent is valid for up to 5 years unless you cancel it in writing. You can submit an original signed copy, a scan, photocopy or fax.

X Witness signature	
Date (YYYY-MM-DD)	
First name of witness (print)	Middle name
Last name(s)	Telephone number

To be completed by a witness only if the applicant signs with a mark (e.g. X). I have read the contents of this section to the applicant, who appeared to fully understand them and who made their mark in my presence.

X  
Signature of applicant / legal representative  
*Debra Robinson*

Date (YYYY-MM-DD)  
*MAR 31 2025*

I give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above. I understand that this information may help determine if I qualify or continue to be eligible for CPP disability benefits or in assessing incapacity under the CPP or OAS Act. I also understand that the information may be disclosed to the SST.

I do not give my consent to Service Canada to obtain medical and other personal information about me from all persons and organizations listed above.

I understand that if I do not give my consent, Service Canada:

- will make a decision based on my application or request for reconsideration based on the available information in my file;
- may stop paying me the benefits if I am already receiving them; and
- can require that I provide the necessary information.

Note: You must choose one option below. Failure to choose an option below could cause a delay in processing your application or determining benefits amounts.

I give Service Canada my consent to collect personal information about me from third parties that could be used by ESDC, Service Canada or the Social Security Tribunal (SST) to help determine if I qualify or continue to be eligible for CPP disability benefits, or help in the assessment of incapacity under the CPP or OAS Act. For this reason, Service Canada may contact any of the following persons and organizations if necessary:

- medical doctors, nurse practitioners, consultant specialists, or other health care professionals;
- educational institutions or other vocational agencies;
- accountants or bookkeepers for information on self-employment;
- federal, provincial, territorial, or municipal government departments and agencies;
- provincial or territorial workers compensation boards;
- financial institutions - for address updates only;
- medical facilities or hospitals;
- administrators of insurance plans, long-term care facilities or retirement homes, medical records storage facilities;
- employers, former employers;
- volunteer organizations;
- employees or former employees for cases of self-employment.

I give Service Canada my consent to collect personal information must be completed and returned with this Medical Report. Your doctor or nurse practitioner can make a photocopy of this consent for their records.

Section 2 - Consent for Service Canada to collect personal information

PROTECTED B (when completed)

Social Insurance Number: [ ]

**Sections 3 to 9 must be completed by a doctor or nurse practitioner****Instructions**

Your patient is applying for Canada Pension Plan (CPP) disability benefits. To help us determine if they are eligible, please complete this form on their behalf. Note that we may contact you if we require additional information.

**Do not remove any pages from this medical report. You must return all 10 pages of this report.**

Under CPP legislation, Service Canada is responsible for deciding if a person is disabled. According to the legislation, a disability must be a mental and/or physical impairment(s) that is both **severe and prolonged**.

- **Severe** means that a person has a mental and/or physical disability that regularly stops them from doing any type of substantially gainful work/occupation; and
- **Prolonged** means that the disability is long-term and of indefinite duration or is likely to result in death.

The legal test for CPP disability is one of medical impairment and employability. In other words, does the severe and prolonged disability prevent the person from working at any job? To decide if the disability meets this legal test, Service Canada looks at the combined impact of:

- the objective medical findings;
- the functional limitations, as reported by both the patient and their health care professional; and
- the person's age, education, and work experience.

**Privacy Notice Statement**

The information collected will assist Service Canada in determining if you are eligible or continue to be eligible for benefits under the Canada Pension Plan (CPP). It may also be used to complete an incapacity assessment under the CPP and the *Old Age Security Act (OAS Act)*. The information may be collected and used at any stage of the decision-making process by Service Canada. It may also be collected and used during any appeals before the Social Security Tribunal (SST).

The authority to collect personal information to determine if you are eligible or continue to be eligible for CPP disability benefits is provided under sections 44, 68 and 69 of the *Canada Pension Plan Regulations (CPP Regulations)*. The authority to collect personal information to complete an incapacity assessment is provided under sections 55.3 and 60 (8) to (11) of the CPP and section 28.1 of the *OAS Act*. The authority to collect information during appeals at the SST is provided under sections 4 and 5 of the *Privacy Act*.

Once collected, your personal information will be used in accordance with the CPP, the *OAS Act*, the *Department of Employment and Social Development Act (DESDA)* and the *Privacy Act*. You have the right to the protection of, and access to, your personal information. Service Canada cannot disclose your personal information to any person or organization without your written consent except where authorized by the DESDA. It will be retained in Employment and Social Development Canada's (ESDC) Personal Information Banks (PPU 116, 146, and 175). You can ask to see your file by contacting a Service Canada office.

Instructions for accessing your personal information are provided in the government publication entitled, *Information about programs and information holdings*, available at [www.canada.ca/infosource-ESDC](http://www.canada.ca/infosource-ESDC) and accessible online at any Service Canada Centre.

You have the right to file a complaint with the Privacy Commissioner of Canada regarding the institution's handling of your personal information at [www.priv.gc.ca/en/report-a-concern/file-a-formal-privacy-complaint/](http://www.priv.gc.ca/en/report-a-concern/file-a-formal-privacy-complaint/) or by calling 1-800-282-1376.

Social Insurance Number:

PROTECTED B (when completed)

### Compensation

To compensate you for completing the report, Service Canada will pay up to \$85 directly to you. To ensure prompt payment, submit the completed report and your invoice as quickly as possible.

Your invoice must include the patient's name, address, and identification number. For income tax purposes, your invoice must also include one of the following:

- your Business Number (BN); or
- your Goods and Services Tax (GST) / Harmonized Sales Tax (HST) number; or
- your Social Insurance Number (SIN).

Without the appropriate numbers, your medical invoice cannot be processed.

Without this information, you and/or Service Canada may be subject to a fine as noted in the *Income Tax Act*, paragraph 221(1).

### Submitting the Medical Report

Please return the completed report directly to Service Canada. If you send us the report on your patient's behalf, please advise them.

**A delay in the completion of this medical report may affect your patient's entitlement to benefits due to lack of medical information.**

If you have any questions, contact Service Canada at 1-800-277-9914 (TTY users: 1-800-255-4786).

To retain a copy of the **Consent for Service Canada to collect personal information (Section 2)** for your records, please make a photocopy and return the original with the completed **Medical Report**. If you require an original signature, the form (ISP2502) can be found at [www.canada.ca/esdc-forms](http://www.canada.ca/esdc-forms).

### Section 3 - Duration of relationship with the patient

This information will help Service Canada confirm that we have the patient's complete medical history.

How many years has this patient been in your care?

- 1 year or less     1 to 2 years     3 to 4 years     5 years or more

Number of times this patient has visited your office in the past 12 months: 5

Date of last office visit (YYYY-MM-DD): 2025-03-11

Date you first started treating this patient's primary medical condition (YYYY-MM-DD): 2017-05-11

#### Section 4 - Expedited processing for terminal and grave conditions

This section should be completed **ONLY** if your patient has been diagnosed with a terminal illness or one of the grave conditions listed in **Annex A**. If your patient does not have a terminal illness or a grave condition, skip to **Section 5**. Do not remove this page.

Applications from patients with a terminal illness or a grave condition receive priority handling. In these cases, once we receive a complete application, including the **Medical Report**, our goal is to determine the applicant's eligibility for CPP disability benefits within 5 business days for applicants with a terminal illness and 30 calendar days for those with a grave condition.

Does your patient have a medical condition that is:

- a) **Terminal** - for the purpose of CPP, terminal is defined as a disease state that cannot be cured or adequately treated and is reasonably expected to result in death within 6 months.

Yes - (provide details below)

Diagnosis	ICD-9-CM code (XXX.X)	Date of symptom onset (YYYY-MM)
Polytraumatisé Mai 2017 Encéphalopathie traumatique		11 mai 2017

If the patient has other non-terminal medical conditions that prevent them from regularly working at any job, please provide details in **Section 5 - Medical conditions, impairments, functional limitations and treatment**. Otherwise, please skip to **Section 6 - Patient's employment situation**.

OR

- b) **Grave** - for the purpose of CPP, grave is defined as a condition that is included in the list of severe and rapidly progressive medical conditions in **Annex A**.

Yes (provide details in **Section 5 - Medical conditions, impairments, functional limitations and treatment**)

#### Section 5 - Medical conditions, impairments, functional limitations and treatment

This section collects information about the medical condition(s), the associated impact on the patient's functional abilities, and the expected course of illness.

See **Annex B** for examples of functional limitations and **Annex C** for examples on completing this section.

Social Insurance Number:

PROTECTED B (when completed)

**Section 5 - Medical conditions, impairments, functional limitations and treatment**

Please use one page per medical condition. List the medical conditions in order of greatest functional impact.

Patient height (centimeters): <b>5'9"</b>		Patient weight (kilograms): <b>198 lbs.</b>	
Medical condition:			
ICD-9-CM code (XXX.X):			
Date of symptom onset (YYYY-MM): <b>Mai 2014 (Accident d'auto.)</b>			
Impairment(s): <b>Encéphalopathie traumatique chronique Syndrome de douleur chronique.</b>			
Functional limitation(s): <b>↓ mobilité. Utilise canne au besoin. Ne peut marcher de longues distances - doit prendre périodes de repos.</b>			
<b>Prognosis</b> Condition is likely to: <input type="radio"/> improve <input type="radio"/> deteriorate <input checked="" type="radio"/> remain the same <input type="radio"/> unknown* <small>* If prognosis and/or frequency is unknown, please explain why in Section 7 - Other relevant information.</small>			
Expected duration: <input type="radio"/> less than 1 year <input checked="" type="radio"/> more than 1 year			
Frequency: <input type="radio"/> recurrent/episodic <input checked="" type="radio"/> continuous <input type="radio"/> unknown* <small>* If prognosis and/or frequency is unknown, please explain why in Section 7 - Other relevant information.</small>			
Medication(s), dosage and frequency	Actual/proposed start date (YYYY-MM)	Actual/estimated end date (YYYY-MM)	Response (e.g. efficacy, side effects etc.) and other remarks
<b>Hydromorpnone</b>	<b>2017</b>	<b>A présent.</b>	<b>Soulage la douleur partiellement.</b>
Type and frequency of other treatment(s)	Actual/proposed start date (YYYY-MM)	Actual/estimated end date (YYYY-MM)	Response (e.g. efficacy, side effects etc.) and other remarks
<b>Physiothérapie</b>	<b>Au besoin.</b>		
<b>Massothérapie</b>			

Social Insurance Number:

PROTECTED B (when completed)

**Section 5 - Medical conditions, impairments, functional limitations and treatment**

Medical condition: *Déficiences cognitives.*  
ICD-9-CM code (XXX.X): *Insomnie sévère. Dépression.*  
Date of symptom onset (YYYY-MM):

Impairment(s): *Problème de mémoire & d'attention.  
Épouse s'occupe de lui à la maison, gérer médication & finances.*

Functional limitation(s): *Problème de mémoire - incapable de concentrer, résoudre problème, a besoin d'aide mémoire & calendrier.*

Prognosis  
Condition is likely to:  improve  deteriorate  remain the same  unknown\*

\* If prognosis and/or frequency is unknown, please explain why in Section 7 - Other relevant information.

Expected duration:  less than 1 year  more than 1 year

Frequency:  recurrent/episodic  continuous  unknown\*

\* If prognosis and/or frequency is unknown, please explain why in Section 7 - Other relevant information.

Medication(s), dosage and frequency	Actual/proposed start date (YYYY-MM)	Actual/estimated end date (YYYY-MM)	Response (e.g. efficacy, side effects etc.) and other remarks
<i>Citalopram 10mg die</i>	<i>2017</i>	<i>à présent</i>	<i>Bonne</i>
<i>Zopiclone 7.5mg hs</i>	<i>2017</i>	<i>à présent</i>	<i>"</i>
<i>Melatonin 10mg hs</i>	<i>2017</i>	<i>à présent</i>	<i>"</i>

Type and frequency of other treatment(s)	Actual/proposed start date (YYYY-MM)	Actual/estimated end date (YYYY-MM)	Response (e.g. efficacy, side effects etc.) and other remarks

Social Insurance Number:

PROTECTED B (when completed)

**Section 5 - Medical conditions, impairments, functional limitations and treatment**

Medical condition: *Masse rénale droit. - Cancer?*  
ICD-9-CM code (XXX.X):  
Date of symptom onset (YYYY-MM): *2024 - Novembre.*

Impairment(s):  
*Pt. attends début Tx Radio.  
en mai 2025.*

Functional limitation(s):  
*/*

Prognosis  
Condition is likely to:  improve  deteriorate  remain the same  unknown\*  
\* If prognosis and/or frequency is unknown, please explain why in Section 7 - Other relevant information.

Expected duration:  less than 1 year  more than 1 year

Frequency:  recurrent/episodic  continuous  unknown\*  
\* If prognosis and/or frequency is unknown, please explain why in Section 7 - Other relevant information.

Medication(s), dosage and frequency	Actual/proposed start date (YYYY-MM)	Actual/estimated end date (YYYY-MM)	Response (e.g. efficacy, side effects etc.) and other remarks
<i>Ø a l'instant.</i>			
Type and frequency of other treatment(s)	Actual/proposed start date (YYYY-MM)	Actual/estimated end date (YYYY-MM)	Response (e.g. efficacy, side effects etc.) and other remarks

For additional medical condition(s), please attach an extra sheet.

**Section 6 - Patient's employment situation**

This section gathers information to assess current and future restrictions on the patient's ability to work.

1. Did you recommend to your patient that they stop working?

- Yes, I recommended that the patient stop working as of (date): 2017.  
 YYYY-MM-DD
- No
- Not discussed

If you have indicated that your patient has a terminal medical condition, skip the rest of this section.

2. From a strictly medical standpoint, do you expect your patient to return to any type of work in the future?

- Yes (please complete questions 3 and 4, below)
- No (skip to Section 7)
- Unknown (skip to Section 7)

3. If yes, please indicate when you expect your patient to return to work:

- In 6 to 12 months     In 12 to 24 months     In more than 24 months     Unknown

4. If yes, please indicate what type of work you expect your patient will be able to do:

- Usual work     Modified work     Another type of work that will require training
- Other: \_\_\_\_\_

**Section 7 - Other relevant information**

To help us evaluate the applicant's current and future ability to work, please add any other information you feel is relevant (e.g. planned investigations and/or specialist consultations, reason for unknown prognosis and/or frequency, etc.).

Depuis son accident de 2017, M. Robichaud demeure invalide de façon marquée. Sa mobilité a quand même amélioré - doit utiliser Canne / marchette au besoin. Douleur chronique jambes, chevilles, ankylose du mandibule. Requiert de l'aide pour AVQ, habillement, problème d'équilibre persiste. Problème de mémoire, d'attention et d'organisation. Ne peut gérer routine medicam, finances, rendez-vous ect. Epouse s'en occupe.

Social Insurance Number:

PROTECTED B (when completed)

### Section 8 - Supporting documents

If you have supporting documents for any of the relevant medical conditions listed in Section 4 or Section 5, please include copies of these reports with this Medical Report.

Please identify the type of report(s) you are including:

- longitudinal clinical notes
- medical investigation report(s)
- specialist's report(s)
- hospital discharge report(s)
- other (please specify): \_\_\_\_\_

### Section 9 - Declaration

I confirm that, to the best of my knowledge all of the information I have provided in this report is accurate and complete.

I am a:

- general practice physician or physician certified in family medicine (CCFP)
- other physician specialist (please specify): \_\_\_\_\_
- nurse practitioner
- registered nurse in a geographically isolated community (not urban or rural)

<b>Name</b> Dr. Hubert Dupuis	<b>Address and telephone number</b> (Please print or use a stamp) 4600 Route 134 Cocagne, N.-B. E4R 2Z3 576-7296 Fax 576-8287.
<b>Signature</b> X <i>Hubert Dupuis MD</i>	
<b>Date (YYYY-MM-DD)</b> 2025-04-01	

### Where to send the completed Medical Report

*Sharon Cormier RN.*

Mail the completed Medical Report and supporting documents to the Service Canada location that serves the province/territory where your patient resides (see a list of addresses on the next page). Please remove the annexes before mailing the Medical Report.

### For patients currently living outside Canada

Mail the completed Medical Report to the office serving the province/territory where the patient last lived. If unsure, please verify with the patient. Please remove the annexes before mailing the Medical Report.



Service  
Canada

## Service Canada Offices Disability

Mail your forms to the nearest Service Canada office listed below.

From outside of Canada, send your forms to the Service Canada office in the province/territory where you last lived.

### **Newfoundland and Labrador**

Service Canada  
PO Box 9430 Station A  
St. John's NL A1A 2Y5  
CANADA

### **Nova Scotia and Prince Edward Island**

Service Canada  
PO Box 1687 Station Central  
Halifax NS B3J 3J4  
CANADA

### **New Brunswick and Quebec**

Service Canada  
PO Box 250  
Fredericton NB E3B 4Z6  
CANADA

### **Ontario**

Service Canada  
PO Box 2020 Station Main  
Chatham ON N7M 6B2  
CANADA

### **Manitoba and Saskatchewan**

Service Canada  
PO Box 818 Station Main  
Winnipeg MB R3C 2N4  
CANADA

### **Alberta / Northwest Territories and Nunavut**

Service Canada  
PO Box 2710 Station Main  
Edmonton AB T5J 2G4  
CANADA

### **British Columbia and Yukon**

Service Canada  
PO Box 1177 Station CSC  
Victoria BC V8W 2V2  
CANADA

If you have any questions, call us.

In Canada or the United States: 1-800-277-9914

For all other countries: 613-957-1954 (we accept collect calls)

TTY: 1-800-255-4786

**Important:** Please have your Social Insurance Number ready when you call.

## Annex A - List of grave medical conditions

The following list of severe and rapidly progressive medical conditions was developed based on extensive research by Employment and Social Development Canada. These conditions with marked and severe functional limitations have a high probability of meeting the CPP disability benefit eligibility criteria, and may result in death. For that reason, applications from patients with any of these conditions receive expedited processing.

1. Acute Lymphoblastic Leukemia
2. Acute Myeloid Leukemia
3. Adrenocortical Cancer
4. Alzheimer's Disease: Early Onset (less than age 60)
5. Amyloidosis
6. Amyotrophic Lateral Sclerosis (ALS)
7. Anal Cancer
8. Appendiceal Cancer
9. Bladder Cancer (Metastatic/Stage IV)
10. Brain Cancer
11. Breast Cancer (Metastatic/recurrent)
12. Cervical Carcinoma
13. Chronic Kidney Disease (CKD)
14. Chronic Liver Disease
15. Colorectal Cancer
16. Endometrial Cancer
17. Esophagus Cancer
18. Follicular Lymphoma
19. Frontotemporal Dementia (FTD)
20. Gallbladder Cancer
21. Huntington Disease
22. Idiopathic Pulmonary Fibrosis (IPF)
23. Kidney Cancer
24. Liver Cancer
25. Lung Cancer
26. Malignant Melanoma
27. Malignant Tumours of Small Intestine
28. Multiple Myeloma
29. Muscular Dystrophy (Adult Onset)
30. Ovarian Cancer
31. Pancreatic Cancer
32. Parkinson's Disease
33. Post Inflammatory Pulmonary Fibrosis
34. Primary Cerebellar Degeneration
35. Progressive Polyneuropathy
36. Quadriplegia/Quadriplegia
37. Schizophrenia
38. Stomach Cancer
39. Thymus Cancer
40. Uterine Sarcoma
41. Vascular Dementia

## **Annex B - Examples of functional limitations**

### **Physical abilities**

Includes restrictions related to:

- changing body position (e.g. kneeling or squatting)
- maintaining body position (e.g. remaining seated or standing)
- fine hand use (e.g. turning a dial or knob)
- hand and arm use (e.g. throwing or catching an object)
- walking (forward, backward, or sideways)
- moving around (e.g. climbing or running around obstacles)
- using transportation (e.g. as a passenger in a taxi or on a bus or subway)
- using a computer (e.g. being able to look at a computer screen for at least 20 minutes)

### **Behaviours and emotional abilities**

Includes restrictions related to:

- basic interpersonal interactions (e.g. showing respect and tolerance)
- complex interpersonal interactions (e.g. regulating emotions and impulses)
- maintaining formal relationships (e.g. with employers or service providers)
- handling stress and other psychological demands

### **Communication and thinking abilities**

Includes restrictions related to:

- making conversation (e.g. with known individuals or strangers)
- acquiring new skills (e.g. learning to use a computer or tool)
- focusing attention (e.g. filtering out distracting noises)
- thinking (e.g. sequencing thoughts in a structured, logical manner)
- making decisions (e.g. identifying and choosing among several options)
- literacy
- numeracy

### **Other daily abilities**

Includes restrictions related to:

- toileting
- dressing
- looking after one's health (e.g. taking medication as directed)
- using communication devices (e.g. using the telephone)
- acquiring goods and services
- maintaining economic self-sufficiency (e.g. managing money)
- doing housework
- preparing meals
- driving

C.P. Drs. H. Dupuis et L. Thibault

Date: 11 mars 2025

Diagnostic(s): ① Masse, incl. A ② Encephalopathie

Procedure(s): Traumatique Ex. @ 9h30

(DONNER A LA SECRETAIRE / GIVE TO THE SECRETARY)

OSCAR ROBICHAUD  
203-54 RUE ST-JEAN-BAPTISTE  
BOUCTOUCHE, NB, E4S 3W7  
NAM: 911 922 508  
DDN: 25/11/1958 TEL: 533-6237

C.P. Drs. H. Dupuis et L. Thibault  
4600 Route 134, Cocagne, NB E4R 2Z3  
Tel.: 576-7296 Fax: 576-8287

Nom: Oscar Robichaud

FRE # REP

R

devenir  
9:00 B.

Consultation(s):

Rendez-vous: Revenir fin 06/25  
15 min.  
Dr. H. Dupuis / M.D.

Date: 11 mars 2025

R.C.: Suivi

TA: 124/74

Pouls: 72

Poids: 198/65

T°:

s. ~~oscar Robichaud~~  
Reçue document  
particulière pour  
Schéle revèle A  
Un Dr. Fillion  
reçoit régulier  
05/25

o. ~~oscar Robichaud~~  
① nouveau fin 06/2025 ou  
suivi et relaps  
Dr. H.

**Guardian**

**Prescription Authorization Request**

**FAXÉ LE**  
31/01/25

To: Dr. Dupuis, Hubert  
4600 ROUTE 134  
Cocagne NB  
E4R 2Z3  
Tel: (506) 576-7296  
Fax: (506) 576-8287

From: Guardian Pharmacie Cocagne  
4813 RTE 134  
Cocagne NB  
E4R 2Y2  
Tel: (506) 576-6262  
Fax: (506) 576-6263  
Pharmacist: GL:cb

Patient: Robichaud, Oscar Joseph  
203-54 St-Jean-Baptiste  
Buctouche NB E4S 2E3  
(506) 291-0030

DOB: 25-Nov-1958

**CONFIDENTIAL**

Rx1015810	<b>Citalopram 10mg TAB</b> Generic Name: Citalopram Hydrobromide DIN 02387948 TAKE 1 TABLET ONCE DAILY	Last Fill 02-Jan-2025 Disp Qty 28	Days Supply: 28	Approved Qty <u>28</u> Repeats <u>1/2</u> H.D.
Rx1015809	<b>Lamotrigine 25mg TAB</b> Generic Name: Lamotrigine DIN 02428202 TAKE 3 TABLET TWICE A DAY (BREAKFAST AND BEDTIME)	Last Fill 02-Jan-2025 Disp Qty 168	Days Supply: 28	Approved Qty <u>168</u> Repeats <u>1/2</u> H.D.
Rx1015808	<b>Pantoprazole-40 40mg TAB</b> Generic Name: Pantoprazole Sodium DIN 02428180 TAKE 1 TABLET ONCE DAILY	Last Fill 02-Jan-2025 Disp Qty 28	Days Supply: 28	Approved Qty <u>28</u> Repeats <u>1/2</u> H.D.
Rx1015807	<b>Opt+ Vitamin D 1000U TAB</b> Generic Name: Vitamin D3 DIN 80003663 TAKE 1 TABLET ONCE DAILY	Last Fill 02-Jan-2025 Disp Qty 28	Days Supply: 28	Approved Qty <u>28</u> Repeats <u>1/2</u> H.D.
Rx1015806	<b>Zopiclone 7.5mg TAB</b> Generic Name: Zopiclone DIN 02385848 TAKE 1/2 TABLET AT BEDTIME	Last Fill 02-Jan-2025 Disp Qty 14	Days Supply: 28	Approved Qty <u>14</u> Repeats <u>1/2</u> H.D.
Rx1015805	<b>Melatonin Time Release 10MG TAB</b> Generic Name: Melatonin DIN 80040522 TAKE 1 TABLET AT BEDTIME	Last Fill 02-Jan-2025 Disp Qty 28	Days Supply: 28	Approved Qty <u>28</u> Repeats <u>1/2</u> H.D.

**Prescriber Certification**

- The prescription represents the original of the prescription drug order.
- The pharmacy addressee noted above is the only intended recipient and there are no others.
- The original prescription has been invalidated and securely filed, and will not be transmitted elsewhere at another time.

Prescriber Name (print name)

*Dr. Hubert Dupuis MD*

ID #

689

Prescriber Signature

Date

31/01/2025





M0599479

HORIZON HEALTH NETWORK  
Department of Medical Imaging

THE MONCTON HOSPITAL

NAME: ROBICHAUD, OSCAR JOSEPH  
DATE OF BIRTH: 25/11/1958  
ACCOUNT #: CI077703/24  
REQ #: 24-0162534  
ROOM #:  
UNIT #: M0599479

EXAM DATE: 23/10/24  
DICTATION DATE/TIME: 30/10/24/1349  
REPORT DATE/TIME: 30/10/24/1355  
PRINTING DATE/TIME: 30/10/24/1355  
Dictated By: BROWN, DOUGLAS L  
MD, FRCPC

CT2410230046 CT/RENAL TUMOR SCAN  
Signed

*Text, SQR  
Cellular R/O telephonique  
dictation  
GDH*

History: Right renal exophytic lesion on chest CT.

Technique: CT renal tumour protocol was performed.

Findings:

There is a lobulated enhancing mass right anterior upper pole renal cortex measuring 2.6 x 2.4 cm.

Left kidney unremarkable.

The renal veins and IVC are clear.

No enlarged lymph nodes identified.

The liver, adrenals, gallbladder and pancreas are unremarkable.

Prior splenectomy.

Moderate atherosclerosis. No AAA.

Lung bases are well-aerated.

*va voir  
Spécialiste Jardi.  
28/11/24*

E-signed in SQR by: BROWN, DOUGLAS L MD, FRCPC

ORDERING PHYSICIAN: MCKENNA, PAUL MD  
PRIMARY CARE PHYSICIAN: DUPUIS, HUBERT (GDH)  
CC: DUPUIS, HUBERT (GDH)

/RAF

REP NUM: 3010-0436

REPORT STATUS: Signed

PATIENT NAME: ROBICHAUD, OSCAR JOSEPH / REQUISITION NUMBER: 24-0162534

PT UNIT #: M0599479

*S?* *JL*

Left femoral IM rod. No aggressive osseous lesion.

Impression:

2.6 cm right upper pole renal cortical mass consistent with neoplasm. Urology consultation recommended.

Priority report was requested to be printed in film library to fax communication of UNUSUAL OR UNEXPECTED FINDINGS to referring Clinician on 30/10/2024 at 01:49:05 PM

Document ID: 14071375

E-signed in SQR by: BROWN, DOUGLAS L MD,FRCP

ORDERING PHYSICIAN: MCKENNA, PAUL MD  
PRIMARY CARE PHYSICIAN: DUPUIS, HUBERT (GDH)  
CC: DUPUIS, HUBERT (GDH)

/RAF

REP NUM: 3010-0436 REPORT STATUS: Signed  
PATIENT NAME: ROBICHAUD, OSCAR JOSEPH / REQUISITION NUMBER: 24-0162534

PT UNIT #: M0599479

Primary Care Physician's copy  
PAGE 2 of 2

Dr. Troy Sitland, MD FRCSC

Adult Urology

Suite 412, 100 Arden St.

Moncton, NB E1C 4B7

Ph: (506) 857-4780 Fax: (506) 857-4786

Nov 28, 2024

Dr. Hubert Dupuis  
4600 Route 134  
Cocagne, NB  
E4R 2Z3

Dear Dr. Hubert Dupuis:

**Re: Oscar Robichaud Nov 25, 1958 Age: 66 yr HN: 911 922 508**

**CHIEF COMPLAINT:**

Suspicious right upper pole renal mass found incidentally on imaging

**HPI TODAY: 28/11/2024:**

Initially identified with small renal lesion (2-3mm) in 2017 during trauma workup following head-on collision with transport truck. Recent imaging shows growth to 2.5-3cm mass in right kidney, upper pole. Mass appears solid, and enhancing, concerning for renal cell carcinoma. Growth has been slow over 7 years.

Significant trauma history from 2017 accident including: 14 broken ribs, three cervical fractures, splenectomy, abdominal trauma requiring laparotomy, jaw injury with limited mouth opening. Was in coma from 11/05/2017 to 04/09/2017. Had hernia repair in 2023.

**PMH, PSH, MEDS, ALLERGIES, SH, and FH:**

PMHx: MVA trauma 2017

PSHx: Splenectomy, exploratory laparotomy, hernia repair 2023

Meds: Citalopram, lamotrigine, melatonin, zopiclone

FHx: Mother deceased from kidney disease requiring dialysis

Work: Previous employment at glass plant for 31 years

**PHYSICAL EXAMINATION:**

Physical exam unremarkable, abdomen soft and non-tender, rest unremarkable

**ASSESSMENT AND PLAN:**

66-year-old with incidentally found 2.7 cm right renal mass, concerning for renal cell carcinoma.

**Right Renal Mass**

Assessment: Small (2.7 cm) solid renal mass, likely renal cell carcinoma

Plan: Conservative management with surveillance imaging in 6 months given extensive abdominal surgical history and associated operative risks

Counseling: Discussed surgical options including partial nephrectomy vs ablation. Surgical approach complicated by extensive intra-abdominal adhesions from previous trauma surgery. Given slow growth and current size, observation is reasonable option.

*Dr. Dupuis  
avise.*

*F.  
SC*

**Re: Oscar Robichaud Nov 25, 1958 Age: 66 yr HN: 911 922 508**

**FOLLOW UP:**

Surveillance imaging in 6 months, then yearly if stable. 3 phase renal mass protocol CT scan..

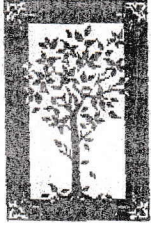
**SHORT SUMMARY:**

66-year-old with small right renal mass found incidentally. Given extensive surgical history and slow growth, plan for surveillance imaging rather than immediate intervention.

Yours truly,

Dr. Troy Sitland, M.D., F.R.C.S.C.

\*Please excuse any transcription errors as this letter was generated using voice recognition software and was not reviewed in order to expedite delivery.



*NR Rehab Services Inc.*  
*Services de Réadaptation NR Inc.*

**Professional Consent Form**  
**Formule Professionnelle de Consentement**

I hereby authorize a representative of *NR Rehab Services Inc.* to review and obtain copies of all hospital, medical, vocational, and other related records related to the automobile accident of \_\_\_\_\_ and to discuss pertinent information with professionals involved in my rehabilitation/case management program. Furthermore, I hereby give permission to *NR Rehab Services Inc.* to share the information received with \_\_\_\_\_ the insurance company or otherwise that is paying all or part of the cost of my rehabilitation/case management program.

J'autorise, par la présente, les représentants de *Services de Réadaptation NR Inc.* d'obtenir et réviser les copies de rapports parvenant des hôpitaux, rapports médicaux liés à l'accident d'automobile du 11 mai 2017. Aussi, de discuter et d'échanger avec les professionnels impliqués dans mon programme de réadaptation toutes informations pertinentes. En apposant ma signature ci-dessous, je permets *Services de Réadaptation NR Inc.* d'échanger avec Assurance Wawanesa les institutions impliquées ou autres qui absorbent les coûts de mon programme de réadaptation toutes informations reçues.

Signed/Signature: \_\_\_\_\_

Address/Adresse: \_\_\_\_\_

Apt 203-54 rue St. Jean Baptiste

Bouctouche, N. B.

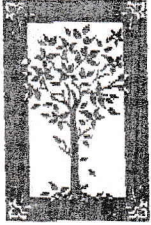
E4S 3W7

Date: \_\_\_\_\_

25/5/2018

Witness/Témoin \_\_\_\_\_

N. Roy



NR Rehab Services Inc.  
Services de Réadaptation NR Inc.

F.M.D. QUESTIONNAIRE

Client: Oscar Robichaud  
File #: 997609  
For: Dr. Hubert Dupuis, MD  
Date: February 28<sup>th</sup> 2019

Following your review of the attached Neuro-Psychology report from the evaluation performed by Dr. S. Kennepohl, on January 28<sup>th</sup>/29<sup>th</sup> 2019, I would appreciate if you could review the below questions pertaining to Mr. Robichaud's care.

1. Do you agree with the findings outlined in the conclusion of Dr. Kennepohl's report?

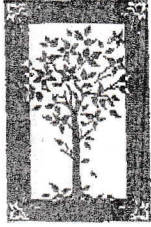
Yes

No If no, could you please explain?

2. In your opinion Dr. Dupuis, is Mr. Robichaud is able to return to work to his pre-MVA employment of an electrician at this time?

Yes

No, If no, could you please explain?



NR Rehab Services Inc.  
Services de Réadaptation NR Inc.

3. If he remains unable to RTW to his pre-MVA employment, would Mr. Robichaud be cleared to return to work to any occupation that he can physically/cognitively complete?

Yes

No, If no, could you please explain when this could be done?

4. In your opinion Dr. Dupuis, would it be beneficial to complete a Cognitive Functional Capacity Evaluation to help better guide return to work process?

Yes

No If no, could you please explain?

Comments:

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Signed by: Dr. H. Dupuis, MD

Date

**STATEMENT OF CREDENTIALS**  
**STEPHAN KENNEPOHL, PH.D., ABPP (CN)**

Dr. Stephan Kennepohl obtained his Ph.D. in Clinical Psychology from the University of Windsor (Ontario) in 2001. He has been a registered psychologist (and neuropsychologist) in Québec since 2002 and obtained his licensure as a psychologist in New Brunswick in 2017. He is Board certified in Clinical Neuropsychology from the American Board of Professional Psychology since 2012. Dr. Kennepohl has been conducting independent neuropsychological examinations since 2005. Prior to this, he held clinical positions in various hospitals and rehabilitation centres in the Montréal area, including the Institut de Réadaptation Gingras-Lindsay de Montréal (IRGLM), the Centre de réadaptation Lucie-Bruneau (CRLB) and the Centre hospitalier de l'Université de Montréal (CHUM). He is also actively involved in teaching and clinical training of psychology students for over 10 years. From 2008 to 2013, he was the Director of the Clinique universitaire de psychologie (training clinic for doctoral students) at the Université de Montréal. He has worked as a clinical supervisor of neuropsychological practice since 2007, including as a part-time University Professor at the UQTR in 2014-2015. He has taught various undergraduate and graduate courses focusing on cognition and neuropsychological assessment. Dr. Kennepohl has contributed to a number of scientific research projects and publications, most notably in the areas of mild traumatic brain injury (mTBI) rehabilitation and the impact of cultural factors on neuropsychological assessment.

**RECOGNITION OF THE INDEPENDENT EXAMINER'S OBLIGATIONS**

1. I, Stephan Kennepohl, am duly licensed to work as a psychologist in the province of New Brunswick.
2. My services have been retained by Mr. Adam Roy, of NR Rehab Services to provide my professional opinion regarding specific questions outlined in the referral.
3. I hereby recognize that it is my duty to provide my opinion and testimony based on the following principles:
  - (a) To provide an objective, impartial opinion;
  - (b) To provide a professional opinion that is limited to my area of expertise;
  - (c) To examine any additional information, if the Court deems it necessary.
4. By the present, I recognize that the above-stated principles supersede any duty or obligation owed to any party that has retained my services.

Date Jan 28, 2019

Signature \_\_\_\_\_



## INDEPENDENT NEUROPSYCHOLOGICAL EVALUATION REPORT

NAME: ROBICHAUD, Oscar  
BIRTH DATE: November 25, 1958  
ASSESSMENT DATES: January 28, 29, 2019  
DATE OF REPORT: February 21, 2019

**ASSESSMENT SUMMARY:** *Mr. Oscar Robichaud is a 60-year-old bilingual man who sustained a severe traumatic brain injury as a result of a motor vehicle accident on May 11, 2017. He is referred for a neuropsychological evaluation to assess any potential residual cognitive deficits and to make recommendations regarding a potential return-to-work. Given the extent and severity of his initial injuries, there can little doubt that Mr. Robichaud has made a rather remarkable cognitive recovery. However, the results of the current neuropsychological assessment nevertheless confirm some rather significant neurocognitive deficits, particularly as they relate to more complex attentional control and executive functioning. These neurocognitive deficits – including some related neurobehavioral symptoms such mild impulsivity, increased fatigue and poor insight - are most likely the direct result of the traumatic brain injury suffered on May 11, 2017. In light of the observed findings, Mr. Robichaud's clinical presentation appears to meet the criteria for a Mild Neurocognitive Disorder Due to Traumatic Brain Injury. Although he may well be able to continue performing most of his day-to-day activities, I believe he still presents a number of functional limitations, particularly in the execution of more complex cognitive tasks. In light of his neurocognitive deficits, I would strongly advise against the return to any type of independent work as an electrician that might put him or others at risk. Unfortunately, these limitations are most likely to be permanent.*

### REASON FOR REFERRAL

On January 9, 2019, Mr. Oscar Robichaud is referred for a neuropsychological evaluation by Mr. Adam Roy, adjuster for NR Rehab services inc., on behalf of Ms. Danielle Ettinger of Wawanesa insurance. Besides the evaluation results, I am asked to address the following in this report:

1. Based on testing done, were there any findings, and/or identified deficits in Mr. Robichaud's cognitive performance? If yes could you please explain.
2. Mr. Robichaud's diagnoses related to the MVA of 2017 were a polytrauma with physical and cognitive injuries related to the closed head injury. Both his physical and cognitive status improved with time. He was admitted to the MCH in June to December 2017 and attended the Rehab Day Treatment Program in January 2018 for both physical and cognitive rehab. Based on testing findings of today, could you please explain if Mr. Robichaud has reached his maximum rehab potential related to his previous cognitive deficits related to the accident injuries?
3. Mr. Robichaud expresses that he wants to return to work within his physical/cognitive abilities. Based on evaluation results, I would ask that you please advise of the direction which should be taken in order to assist Mr. Robichaud's vocational management.

**INDEPENDENT NEUROPSYCHOLOGICAL EXAMINATION REPORT – STRICTLY CONFIDENTIAL**

NAME : ROBICHAUD, Oscar

SJ PSYCHOLOGY CENTRE

4. If it is found that there are restrictions/cognitive limitations to Mr. Robichaud returning to work at this time, could you please explain if the identified testing limitations be considered temporary or permanent in nature?
5. If it is found that the limitations are temporary in nature, could you please explain if there are any suggestions identified to assist Mr. Robichaud's return to as near his pre-injury lifestyle as possible and this to include a return to work?
6. Can you please comment on the validity of testing results?

**ASSESSMENT METHODS**

Prior to beginning the assessment, Mr. Robichaud was informed of the mandate, the nature and purpose of the assessment, including the fact that he would have to contact the referring party to obtain a copy of this report. At Mr. Robichaud's request, most of this assessment was conducted in English. However, it often happened that portions of the assessment or conversation reverted in French (including one of the vocabulary subtests); I also supplemented some of the instructions with French in order to ensure comprehension.

The assessment was conducted over the course of two testing days (January 28 & 29, 2019), with several breaks. The assessment consisted of a clinical interview, followed by a battery of select neuropsychological and psychological tests. I also conducted a brief interview with his wife, Ms. Dolorès Robichaud, at the beginning of the second testing day.

A list of all tests/measures used in the current assessment is appended to this report, as well a set of descriptors to aid with the understanding of certain terms. Mr. Robichaud does appear to recall some form of cognitive testing sometime in the autumn of 2017. However, he did not appear to explicitly recognise any of the specific tests or measures used in the present evaluation.

*Review of Available Records*

As stated above, the following information was obtained through a clinical interview with Mr. Robichaud (and his wife), as well as a review of available records provided by the referral source. These include the following:

- Medical records from the Moncton City Hospital- MCH (from May 11 to Dec. 22, 2017; Jan. 20 & May 28, 2018);
- Report written by Dr. J. C McRae (May 11, 2017);
- Report written by Dr. P. W. Goobie (May 11 & June 6, 2017);
- Report written by Dr. M. Rizkalla (May 11 & 13, 2017);
- Reports written by Dr. W. W. Allanach (between May 15, 2017 & March 22, 2018);
- Report written by Dr. B. Telgarsky (May 17, 2017);
- Consultation report written by Dr. A. Akinmokun, psychiatrist (June 13 2017);
- Report written by Dr. L. Leblond (June 16 & Nov. 15, 2017);
- Reports written by Dr. J. Pike, psychiatrist (Feb. 14, July 27, & Nov. 26, 2018);
- Various medical notes and documents written by Dr. H. Dupuis (July 20, 2018);
- Letter of referral from Mr. A. Roy of NR Rehab Inc. (Jan. 9, 2019);

**INDEPENDENT NEUROPSYCHOLOGICAL EXAMINATION REPORT – STRICTLY CONFIDENTIAL**

NAME : ROBICHAUD, Oscar

SJ PSYCHOLOGY CENTRE

In addition to the information provided by the referring party, I made a request to obtain additional information from the MCH (with Mr. Robichaud's formal written authorisation). More specifically, I was interested in obtaining specific reports related to neuroimaging and cognitive testing (including raw test data). Unfortunately, I had not received this additional information at the time of the drafting of this report. If and when this information becomes available to me, I will write a supplemental report, especially if such additional information modifies in any way the conclusions of the present report.

**RELEVANT PERSONAL AND MEDICAL HISTORY**

Please note that the following is a summary of the available information, and only presents the information considered relevant within the context of the present assessment. It should not be seen as an exhaustive description of all information gathered during clinical interview and/or reviewed documents.

*History of Presenting Problem (according to available records)*

According to available medical records, Mr. Robichaud suffered a severe traumatic brain injury (TBI) as a result of a motor vehicle accident (MVA) around 6:30 PM on May 11, 2017. According to the Ambulance Report, Mr. Robichaud was the driver of a pick-up truck involved in a high-speed head-on collision with a tractor-trailer. In light of the "massive intrusion on the driver's side", it took some time to extricate him from the vehicle (i.e., as long as "an hour and a half"; cf. Dr. McRae, May 11, 2017). Although conscious, he was described as being "never fully alert", with "no verbal response". Initial Glasgow Coma Scale was documented as 8/15, going down to 6/15, with reports as low as 3/15 (cf. Dr. McRae; May 11, 2017).

Upon arrival at the Moncton City Hospital (MCH) (cf. Dr. J. McRae; May 11, 2017), he was combative and gaze paresis to the right. Initial GCS score was taken as 6/15, reportedly dropping down to 3/15. He appeared to have a basal skull fracture and multisystem trauma, including a comminuted left femur fracture, and significant intra-abdominal injuries (requiring massive transfusion). Although initial CT scanning did not reveal evidence of closed head injury, there was evidence of facial fractures and a C-spine fracture. On the same day (May 11, 2017), he underwent emergency laparotomy by Dr. Paul Goobie in light of significant intra-abdominal injuries, including a splenectomy and intra-abdominal packing up for liver hematoma.

Another surgical intervention was performed on May 15, 2017 by Dr. William W. Allanach, including an open reduction and internal fixation (ORIF) for a left distal femur fracture and nailing of a femoral shaft fracture.

According to medical notes dated May 24, 2017 (signature is unreadable), a recent MRI had revealed "multiple bihemispheric contusions, SDH [subdural hematoma] and diffuse axonal injury with ataxia". He is described as having a "poor prognosis for functional recovery and neurological recovery".

On June 6, 2017, Dr. Goobie describes the following problems: "closed head injury, cervical fractures, blunted abdominal trauma requiring a laparotomy and splenectomy, femur fracture with open repair".

INDEPENDENT NEUROPSYCHOLOGICAL EXAMINATION REPORT – STRICTLY CONFIDENTIAL

NAME : ROBICHAUD, Oscar

SJ PSYCHOLOGY CENTRE

On June 13, 2017, Mr. Robichaud is seen by Dr. A. Akinmokun, psychiatrist. Following their meeting, Dr. Akinmokun diagnoses an Adjustment disorder with depressed mood secondary to MVA and consequent deficits and limitations. Among the observed symptoms, Dr. Akinmokun describes "evidence of cognitive deficits and word finding difficulties".

On June 16, 2017, Dr. Louis Leblond, orthopedic surgeon, reports a newly diagnosed right talus fracture, only recently discovered due to his "altered level of consciousness".

He was reportedly transferred to the inpatient rehabilitation unit of the Moncton Hospital on July 4, 2017 (cf. Dr. Pike; Feb. 14, 2018).

An open reduction and internal fixation (ORIF) of the right talus is conducted by Dr. LeBlanc November 15, 2017.

Mr. Robichaud is discharged from hospital on December 22, 2017 (Discharge summary, Dr. Allanach: March 15, 2018). In the discharge note, Dr. Allanach notes that he had a "significant head injury" and it was questionable whether or not he was actually going to survive for many days". Subsequently, he was described as having "stabilized nicely", although it took a "long time to get stable enough to be a rehab candidate".

On February 14, 2018, Dr. Jeff Pike, physiatrist, reports the following conditions: Severe closed head injury, right facial fractures, right cervical spine fractures, left femur fracture and right talus fracture as well as splenic rupture, liver hematoma and laceration of the right kidney, laceration of left lower lobe and pulmonary contusion. At that time, Dr. Pike report that "pain management continues to be a problem in his lower extremities" and notes that he is followed in the rehab day treatment program for his cognitive impairments and wheelchair prescription.

A more general hospital report from is produced on May 28, 2018, regarding his hospitalization at the MCH describes, among other problems, some ongoing "short term memory problems". It is noted that his wife manages the finances; there is also some documentation of certain results on cognitive screening measures (e.g., MOCA: 24/ 30 ; NAB-S below average on the attention subtest ; Trails A & B within the norm ; MVPT within normal limits ; Bell's test within the norm). It is noted that occupational therapy goals have been achieved.

On July 20, 2018, his family physician, Dr. Hubert Dupuis notes some improvements in his ambulation ("demarche améliorée").

On July 27, 2018, Dr. Jeff Pike (physiatrist) notes improvements in his gait, as he is able to go without his walker for shorter distances ("although his gait is slow, overall he looks pretty good"). Dr. Pike reports some ongoing concerns about his driver's license (as does his wife, according to Dr. Pike), adding that this will require an assessment through the Stan Cassidy Centre.

On November 26, 2018, Dr. Pike notes that there have not been any recent updates as to his cognitive functioning. Prior reports by Occupational Therapy suggested difficulties with attention and executive functioning. At that time, he had "done well with telling time, counting money,

INDEPENDENT NEUROPSYCHOLOGICAL EXAMINATION REPORT – STRICTLY CONFIDENTIAL

NAME : ROBICHAUD, Oscar

SJ PSYCHOLOGY CENTRE

addressing envelopes, solving daily math problems, writing a check and balancing a checkbook, using a calendar, using a telephone and writing messages, but needed assistance for understanding medication labels". He was also described as having a "tendency to deal with verbal information too quickly, leading to errors"; it was recommended that he have supervision for medication and financial management. According to Dr. Pike, his cognitive skills certainly seem to be sufficient for his current day-to-day activities but higher-level kind of skills will need to be assessed before returning to work requiring cognitive skills. At that time, Dr. Pike states that his wife appeared to have concerns about his ability to drive.

*Other medical / psychiatric history*

When asked about any relevant prior medical history, Mr. Robichaud reports having undergone "nose surgery" around age 36 ("septoplasty" is in the chart note on May 28, 2018). In his notes, Dr. Dupuis also reports a prior history of dyslipidemia ("DLPD") and a reducible inguinal hernia.

When asked about the possibility of prior head injuries, he states that he fell about 30 feet in a barn around age 12, stating that he "broke a bone in his neck". He does not report any loss of consciousness and was never hospitalised. He reports that he saw a physician who "repaired" it; he does not relate any longer-lasting sequelae of the incident. He also states that he fell through a hole in the ice at age 5 years; he was eventually saved by his brother; once again he was not hospitalised and does not report any lasting symptoms.

Mr. Robichaud does not report any prior history of psychiatric or psychological problems.

*Medications*

According to the list provided by Mr. Robichaud, he was taking the following medications at the time of our meetings: melatonin, pantoprazole, lamotrigine, zopiclone, citalopram, and hydromorphone.

*Other interventions*

Mr. Robichaud states that he has been followed by the same family physician (Dr. Dupuis) since age 18. He reports that he no longer has any other regular clinical appointments ("done with rehab").

*Subjective Symptomatology (as reported by Mr. Robichaud)*

When asked about the events surrounding his motor vehicle accident on May 11, 2017, Mr. Robichaud initially states he "doesn't remember anything". Although he does report some vague recollection of telling his wife that he was coming home (on the day of the accident), his last clear memories are of the day before (May 10<sup>th</sup>, his son's birthday). When asked about his first memory for events following the accident, he states that this would be about mid-September 2017, when he recalls seeing and talking to his wife about their grandchildren.

**According to Mr. Robichaud, the only residual problems from his injuries have to do with his legs** ("anything else?" ... "that's it"). He still requires a walker to get around, which he primarily attributes to difficulties with balance because of his right ankle (talus). Indeed, he feels that in some ways, he may be better off cognitively now than before the accident ("100% back ... better than I was").

He does not describe any issues with appetite ("very good") or sleep; he typically goes to bed around 10 PM and gets up around 6 AM. He does not report fatigue and rarely takes naps. He states that walks for about an hour every day. He wears glasses for some aspects of reading ("fine reading") but does not report any other sensory problems (i.e., vision, hearing, smell or taste).

Cognitively, he reports no ongoing issues, even stating that his memory is better in some ways. More specifically, he does not report any problems with attention, word-finding, spatial functioning, or planning / organisation. Indeed, he reports that he remains active, stating that he was planning on applying for a patent for an electric motor he had designed.

With the possible exception some occasional frustration with his insurers ("got pissed off"), he describes his overall mood as "good". He denies any related depression or anxiety-related symptoms (e.g., feelings of sadness, guilt, anhedonia). When asked about any possible changes in his personality, he does admit that he can be more "direct"; however, he claims that this has largely been a positive change. He also notes that he is "more calm" since his accident. He does not believe that others have noted significant changes in his behaviour ("not worse").

During clinical interview, his wife's descriptions appear quite similar to Mr. Robichaud's reports related to his current level of functioning. She does mention that he appears less active now ("moins actif"), noting that he used to be somewhat of a "workaholic". Otherwise, she believes him to be the same person in many ways. She does not notice any major changes in his behaviour, whether in be in terms of his cognition ("pas de problèmes de mémoire") or his personality ("pas moins patient"). She did state that they both had to adjust to some new financial realities following the accident, adding that her husband had learned to adapt ("s'est adapté"). She states that she has adjusted her own work schedule (she now works nights) in order to be able to drive her husband to his various appointments.

Although she does voice some concerns about his driving, at the time of our meeting, these seem specifically related to his physical injuries (most his right leg). She does not report any real concerns about his cognitive capacities ("pour sa tête... où il était") or in terms of his ability to return to work ("pas d'inquiétudes pour le travail").

#### *Psychosocial History*

Mr. Oscar Robichaud is a right-handed, bilingual man. He was aged 65 years at the time of this assessment. He has been married over 40 years to his current wife; they have two adult sons (ages 36 and 39) and four grandchildren.

Mr. Robichaud grew up in a francophone household in Ste-Marie, NB. Although he completed his primary and secondary education in French (until Grade 12), his post-secondary education was done in English. He considers himself completely bilingual, noting a slight preference for English.

He states that he was always a pretty good student, completing Grade 12 and then obtaining subsequent certificates in electrical servicing, electrical instrumentation, and as an industrial electrician (from the NBCC in Moncton). He states that he worked in a glass plant from 1992 to

**INDEPENDENT NEUROPSYCHOLOGICAL EXAMINATION REPORT - STRICTLY CONFIDENTIAL**

NAME : ROBICHAUD, Oscar

SJ PSYCHOLOGY CENTRE

2008, many of those years as a manager. He has been self-employed as an electrician (primarily industrial), since 2008.

At the time of our meeting, Mr. Robichaud stated that he had returned to work, part-time (about 3 days a week), since October 15, 2018. He does not perceive any ongoing problems with his ability to work since that time ("has gone well [...] perfect").

*Substance Use*

Mr. Robichaud does not smoke, drink alcohol, or take other non-prescription drugs. He does not drink coffee but does have about 2-3 cans of Coca-Cola per day.

**FORMAL NEUROPSYCHOLOGICAL / PSYCHOLOGICAL TESTING**

*Behavioural observations*

Mr. Robichaud presents as a very pleasant and engaging individual. His mood appeared generally euthymic, even jovial at times; affect was appropriate, with normal range. Spontaneous speech was quite clear and coherent, although occasionally tangential. He sometimes required re-direction to answer certain questions or stay on task. At one point during clinical interview, he sketched a number of drawings for several minutes, describing his upcoming requests for a patent for an electric motor.

Frustration tolerance is generally quite good, although he sometimes made comments during portions of the assessment (e.g., "doesn't make sense"; "this is hard"; "holy jeez"); this was particularly evident during one of the tasks which posed particular problems (i.e., the Brown-Peterson task). He described as "beyond reality" and seemed to jokingly question its relevance for his situation. There is also some impulsivity noted on certain tasks, leading to more variable performance on certain tasks (e.g., WAIS-IV Visual Puzzles). Some degree of fatigue was noted, particularly towards the end of the second day of testing (e.g., Oral SDMT). However, there was no evidence of more generalised or significant sensory or motor dysfunction that might have interfered with the validity of the testing.

At the end of the second testing session, I asked him about how he felt he had done on the various tasks; with the exception of one task he particularly disliked (i.e., the Brown-Peterson task), he generally felt he had done quite well ("correct").

*Validity of neuropsychological test scores*

In general, Mr. Robichaud performed appropriately on most tasks designed to assess his level of engagement and effort during cognitive testing. Although some scores appeared slightly below more stringent cutoffs on certain PVTs, more generally, the obtained results remained well within acceptable levels. Overall, these results are considered an adequately valid reflection of Mr. Robichaud's current neuropsychological functioning.

*Global Cognitive Functioning*

Mr. Robichaud's scores on a measure of global cognitive functioning (WAIS-IV) were generally within the Low Average to Average range for his age. Although somewhat lower than various estimates of his premorbid functioning, these findings did not suggest a generalised decline in his

global cognitive functioning compared to prior levels. However, this does exclude more focal deficits in specific areas of neurocognitive functioning.

#### *Processing Speed*

There was little evidence of more generalised or severe cognitive slowing. For example, Mr. Robichaud's timed scores on most tasks requiring visual scanning and psychomotor speed were generally well within the average range for his age (e.g., Ruff 2 & 7 test, Coding and Symbol Search of the WAIS-IV, Oral SDMT).

#### *Attentional Control, Working Memory, & Executive Functioning*

However, Mr. Robichaud's performance on most measures of selective attention and working memory was notably lower than expected. Although likely lower than previous levels, he still obtained scores that remained within normal limits on certain simpler tasks (e.g., WAIS-IV Letter-Number Sequencing; WMS-IV Symbol Span – generally near the Low Average range).

In contrast, he clearly struggled when presented with tasks requiring more complex (executive) attentional control, that is, the ability to manipulate and/or maintain his attention when dealing with more complex information. For example, during an oral arithmetic task (of the WAIS-IV), it was quickly evident that Mr. Robichaud is quite good at doing calculations, as reflected in his overall score on this measure (50<sup>th</sup> percentile rank- Average range). However, it was obvious that as soon as the questions required increased working memory "load", that is, the ability to manipulate information in mind quickly and efficiently, his performance dropped quickly. Indeed, he often asks for me to repeat the questions. Furthermore, Mr. Robichaud clearly has trouble during another, more complex attentional task, requiring him retain a string of three letters while performing a competing cognitive task (i.e., subtracting by threes; Brown-Peterson Task). His performance on this task was clearly well below normal levels for his age (all scores  $\leq$  5<sup>th</sup> percentile). Finally, he obtained a number of poorer scores on a measure requiring him to focus and maintain his attention for a more extended period of time (CPT-III). Indeed, he made several inattention-type errors (i.e., high rate of missed targets – omissions) and had difficulties maintaining his level of performance over time (i.e., extremely variable and poorer performance towards the end of the task).

Given the importance of such attentional control in the completion of most complex cognitive tasks, it is expected such deficits might have a significant impact on many of other administered measures, most prominently tasks requiring more "executive" attention. This is clearly evident in Mr. Robichaud's case, as he often demonstrated a more haphazard approach to more complex "executive"-type tasks, including memory tasks where some degree of self-organisation can significantly aid with recall (e.g., CVLT-2, RCFT). Such deficits would also manifest themselves in problems during tasks requiring him to "keep track" of his prior answers, resulting in increased time to perform the task (e.g., Trails B), his losing track of instructions (e.g., during verbal fluency tasks) or having problems benefiting from feedback to adjust his responses (e.g., during the WCST). During the Wisconsin Card sorting task, he was quickly able to ascertain (and name) the relevant concepts required for the test; however, his relative inability to "keep track" of prior responses appeared to affect his overall performance (e.g., only 2 categories).

INDEPENDENT NEUROPSYCHOLOGICAL EXAMINATION REPORT - STRICTLY CONFIDENTIAL

NAME : ROBICHAUD, Oscar

SJ PSYCHOLOGY CENTRE

There were also indications of increased difficulties with some aspects of more abstract reasoning, as evidenced by some decreased scores on certain more complex measures (e.g., WAIS-IV Similarities, Matrix Reasoning; < 10<sup>th</sup> percentile rank).

However, this does not necessarily translate into a more generalized dysfunction affecting all aspects of executive functioning, as Mr. Robichaud seemed capable of perform adequately on some of the tasks typically associated with executive functioning. Indeed, he obtained scores within the normal range (for his age and educational level) on tasks requiring some degree of flexibility and/or resistance to disinhibition (e.g., RFFT, D-KEFS Color-Word Interference).

#### *Language*

Mr. Robichaud did not demonstrate any significant generalised deficits in language functioning. He did obtain somewhat lower scores on measures assessing prior word knowledge, in both in French and English (i.e., Vocabulary subtests of the francophone WAIS-III and the WAIS-IV). However, this may well represent a more long-standing issue (possibly related to his bilingualism), and does not necessarily reflect an acquired problem. He did exhibit some milder problems on a task typically associated with verbal abstraction ( $\approx$  5<sup>th</sup> percentile), suggesting some problems with flexibility (see *Attentional Control, Working Memory and Executive Functioning*).

In contrast, his score on measure of general knowledge was clearly within the average range (WAIS-IV Information  $\approx$  50<sup>th</sup> percentile rank). Of note, his ability to produce words that are members of a semantic category - with time constraints - was well above average (Animal Naming).

#### *Visuospatial/visuoconstructional skills*

Generally speaking, Mr. Robichaud exhibited relatively intact basic visuospatial skills. His scores on WAIS-IV tasks involving intact visuospatial skills and/or nonverbal reasoning remain within the general normal limits for his age (e.g., PRI  $\approx$  16<sup>th</sup> percentile rank).

In contrast, Mr. Robichaud demonstrated clear difficulties on items involving more complex visuoconstruction skills (e.g., WAIS-IV Block Design, RCFT). Indeed, his reproduction of a more complex geometric design (RCFT) was extremely disorganised and poorly planned, with a number of inattention errors. However, there did not appear to be any major spatial distortions. Of note, Mr. Robichaud seemed to recognize the difference between his reproduction and the model ("jamais aimé dessiné"). These types of difficulties appear particularly noteworthy given his prior occupation as an electrician, and may well be secondary to his decreased working memory and complex attention skills (see *Attentional Control, Working Memory & Executive Functioning*).

#### *Memory*

As a result of his attentional control deficits, Mr. Robichaud's performance on memory tasks was highly dependent on the level of self-organisation required to help with learning and retrieval of the material from memory.

Indeed, he demonstrated some rather telling difficulties on certain relatively unstructured or complex memory tasks, both for verbal and visual material. For example, when presented with an unstructured list of 16 words over the course of five learning trials (CVLT-2), his performance

was quite variable. Although he appeared able to learn several words, his approach was quite disorganised and he tended to repeat himself, leading a somewhat suppressed overall learning score (Trials 1-5  $\approx$  10<sup>th</sup> percentile rank). His retention of these words after a delay was also quite poor; at the end of the task, when asked to recognize the words among a list of distractors, he showed substantial forgetting (recognizing only 10 of the original 16). His recall for a complex geometric figure (RCFT) was also quite poor ( $\leq$  5<sup>th</sup> percentile rank), likely as a result of the rather disorganised approach during the initial copy.

In contrast, Mr. Robichaud appeared much more capable of learning when the information was presented in a more highly-structured or in a step-by-step fashion (thereby decreasing the influence of working memory and more complex attentional control – see *Attentional Control and Working Memory*). For example, he recalled several details related to two narrative stories (WMS-IV Logical Memory – High Average). He also appeared much better at retaining a list of simpler geometric shapes presented one page at a time (WMS-IV Visual Reproduction), although he still showed substantial problems recalling this figures after a delay.

In sum, Mr. Robichaud demonstrated a relatively well-preserved ability to learn and retain various types of information, but only to the extent that it was presented using a more structured format. To the extent that the information requires more self-organisation or attentional control to aid with learning (or recall), his performance was significantly lower.

#### *Psychological and Functional Adaptation*

In order to obtain a general idea of his current psychological state, Mr. Robichaud was asked to complete a lengthier self-report questionnaire designed to assess the presence of symptoms typically associated with various psychopathological conditions (PAI). I also asked him to complete a brief questionnaire documenting the presence or absence of any "post-concussive" symptoms (PCSQ-19). Finally, he was asked to complete a short self-report measure assessing his perception of the impact of his health condition on everyday functioning (WHODAS 2.0).

Analysis of validity indicators on the PAI suggests that Mr. Robichaud answered some of the questions in a slightly haphazard or inconsistent manner. In theory, such findings decrease the validity of the obtained results, making more detailed and precise conclusions regarding his psychological status more difficult.

Having said that, such a tendency – including a more disorganised approach – does appear in keeping with other aspects of his cognitive and behavioural profile. Indeed, many of his answers appear quite consistent with his responses during clinical interview, suggesting a strong tendency to minimise and underreport problems (psychological or otherwise) in his everyday functioning. Indeed, Mr. Robichaud reports the virtual absence of any preoccupations regarding his overall health situation, including most problems related to mood, cognition, or somatic symptoms. In that vein, it should be noted that he does not endorse any of the related "post-concussion" symptoms from a related questionnaire (PCSQ-19).

Unsurprisingly, with the notable exception of issues related to his mobility and related physical problems (see *Description of Subjective Symptomatology*), his responses on the WHODAS 2.0

suggest that Mr. Robichaud reports relatively few problems in his day-to-day functioning. This includes some relatively mild preoccupations concerning his everyday cognition.

#### SUMMARY AND CONCLUSIONS

Mr. Oscar Robichaud is a 60-year-old bilingual man who sustained a severe traumatic brain injury as a result of a motor vehicle accident on May 11, 2017. Among other questions, he is referred for a neuropsychological evaluation to assess any potential residual cognitive deficits and to make recommendations regarding a potential return-to-work.

To begin with, it seems important to point out that Mr. Robichaud has made a rather remarkable cognitive recovery, particularly in light of the apparent extent and severity of his initial injuries. Many of the obtained neuropsychological test results remain well within average levels, and in many regards, he seems to have returned to premorbid levels. Assessment of his current psychological functioning did not reveal any ongoing concerns regarding his mood or any other form of psychological distress. Of particular note, his wife also did not report any significant behavioural changes compared to his pre-accident personality and overall level of functioning.

Having said that, the results of the current neuropsychological assessment nevertheless confirm the presence of rather significant neurocognitive deficits, particularly as they relate to more complex attentional control and executive functioning. These deficiencies are most notable during tasks requiring the ability to manipulate and retain more complex information in working memory; given the importance of such executive attention to most complex tasks, these deficits also “spill over” into a number of other cognitive domains, most notably some aspects of visuoconstruction and memory.

In my opinion, these neurocognitive deficits are most likely the direct result of the traumatic brain injury suffered by Mr. Robichaud on May 11, 2017. More specifically, these deficits, along with some other neurobehavioral symptoms (e.g., mild impulsivity, increased fatigue towards the end of the assessment, decreased insight), appear quite consistent with the consequences of frontal/subcortical dysfunction that is so often associated with these types of injuries.

Of note, Mr. Robichaud does not appear to have very little insight into the nature and severity of the above-mentioned deficits; indeed, he appears to argue that some of his cognitive capacities have improved since the accident (which appears highly unlikely). Although some aspects of this presentation might reflect his pre-accident personality (in the form of “denying” the impact of psychological factors), it is important to emphasize that such decreased insight is quite a common correlate of this type of neuropsychological dysfunction (and most prominently executive deficits). In Mr. Robichaud’s case, this most likely reflects a direct neurobehavioural manifestation of the underlying neurological insult (i.e., also known as “anosognosia”).

In light of the observed findings, Mr. Robichaud’s clinical presentation appears to meet the criteria for a Mild Neurocognitive Disorder Due to Traumatic Brain Injury. In terms of everyday functioning, there is little reason to believe that Mr. Robichaud could not be able to continue to perform many of his day-to-day activities without too much difficulty. In this respect, it is easy to conceive how others, including his wife, might have trouble noticing significant changes in his

cognitive capacities. Once again, it is worth mentioning that given his initial injuries, he has made a rather remarkable recovery.

However, given the observed cognitive deficits, particularly in attentional control and memory, I believe that he will still present with a number of functional limitations, particularly in the execution of more complex cognitive tasks. These difficulties are likely to be most prominent as it relates to his ability to execute more complex cognitive tasks requiring the "juggling" and retention of several bits of information in mind. One would also expect Mr. Robichaud to demonstrate problems with episodic memory (i.e., consciously and deliberately learning and committing information into memory store). Although he does show the ability to learn and retain some new information, his retrieval of such information is sometimes quite limited and poorly organised. It should also be noted that attentional control/working memory deficits are frequently associated with increased fatigue (as observed towards the end of this assessment). These deficits are necessarily compounded by his rather significant lack of insight into his own neurocognitive deficits.

In the following sections, I will attempt to address each of the referring party's questions in turn:

1. Based on testing done, were there any findings, and/or identified deficits in Mr. Robichaud's cognitive performance? If yes could you please explain.  
The findings of the current neuropsychological assessment appear to confirm the presence of some rather notable neurocognitive deficits, most prominently in the areas of attentional control and associated executive functions. These primary deficits also affect his performance in other areas of cognition, most notably in the areas of visuoconstruction and memory. For a more detailed description of the underlying deficits, please see the *Summary and Conclusions* section.  
2. Mr. Robichaud's diagnoses related to the MVA of 2017 were a polytrauma with physical and cognitive injuries related to the closed head injury. Both his physical and cognitive status improved with time. He was admitted to the MCH in June to December 2017 and attended the Rehab Day Treatment Program in January 2018 for both physical and cognitive rehab. Based on testing findings of today, could you please explain if Mr. Robichaud has reached his maximum rehab potential related to his previous cognitive deficits related to the accident injuries?

Although some degree of underlying neurological recovery is still theoretically possible, given the nature/severity of the observed deficits and the period of time that has elapsed since his injury (i.e., more than 18 months post-injury), the possibility of full cognitive recovery seems extremely unlikely. Indeed, the most likely outcome is that the observed cognitive deficits will likely be permanent (even with the possibility of some milder functional improvements).

3. Mr. Robichaud expresses that he wants to return to work within his physical/cognitive abilities. Based on evaluation results, I would ask that you please advise of the direction which should be taken in order to assist Mr. Robichaud's vocational management.

**INDEPENDENT NEUROPSYCHOLOGICAL EXAMINATION REPORT – STRICTLY CONFIDENTIAL**

NAME : ROBICHAUD, Oscar

SJ PSYCHOLOGY CENTRE

Given the nature and severity of the associated neurocognitive deficits, I would **strongly advise against any type of independent or autonomous work as an electrician** that might put him or others at risk. Indeed, this particular line of work appears to be a quite a poor fit given the specific nature of his neurocognitive deficits, which would put him at increased risk for mistakes related to inattention or forgetfulness. Once again, these risks appear **even more significant when one considers his apparent lack of insight into his limitations.**

Arguably, he may still be able to serve in some type of part-time consultancy work, as he is likely to retain much of the underlying knowledge and skills. However, given the risks, this would most likely be in a more "theoretical" role, and may also require some degree of supervision.

4. If it is found that there are restrictions/cognitive limitations to Mr. Robichaud returning to work at this time, could you please explain if the identified testing limitations be considered temporary or permanent in nature?
5. If it is found that the limitations are temporary in nature, could you please explain if there are any suggestions identified to assist Mr. Robichaud's return to as near his pre-injury lifestyle as possible and this to include a return to work?

Unfortunately, given the nature/extent of the cognitive limitations (including his poor insight), as well as the period of time that has elapsed since his accident, it seems highly unlikely that any potential gains would be substantial enough to allow him to return to work to his pre-injury levels in a safe and sustainable manner. Unfortunately, these limitations are **most likely to be permanent.**

6. Can you please comment on the validity of testing results?

There were no significant issues that might be considered to affect the validity of the obtained neuropsychological test results. Overall, these findings should be considered a reasonably reliable and valid measure of his current neuropsychological functioning.

Please note that the above opinions are based on the information available at the time of the writing of this report. It is therefore possible that some new information or documents might therefore result in a modification of the above conceptualisation and conclusions.

If there are further questions or comments regarding the present report, please do not hesitate to contact me directly at the SJ Psychology Clinic at: 506-632-3110.

Stephan Kennepohl, Ph.D., ABPP (CN)  
Neuropsychologist / Psychologist (CPNB Member # 682)  
SJ Psychology Centre

**SUMMARY OF ADMINISTERED TESTS**

Abbreviated version of the WAIS-IV (Block Design, Similarities, Digit Span, Matrix Reasoning, Vocabulary,

Arithmetic, Symbol Search, Visual Puzzles, Information, Coding, Letter-Number Sequencing  
Vocabulaire from the WAIS-III Francophone (CDN)  
WMS-IV Symbol Span, Logical Memory & Visual Reproduction  
Brown-Peterson task (Stues version)

**INDEPENDENT NEUROPSYCHOLOGICAL EXAMINATION REPORT – STRICTLY CONFIDENTIAL**

NAME : ROBICHAUD, Oscar

SJ PSYCHOLOGY CENTRE

D-KEFS Color-Word Interference

Verbal fluency (COWAT, Animals)

Ruff Figural Fluency Test (RFFT)

Wisconsin Card Sorting test (WCST)

Personality Assessment Inventory (PAI)

Post-Concussion Symptom Questionnaire- 19 (PCSQ-19)

WHODAS 2.0

Performance Validity Tests

Trail making test (A & B)

Symbol Digit Modalities Test (SDMT) – oral version

Rey Complex Figure Test (RCFT)

California Verbal Learning Test – 2<sup>nd</sup> Edition (CVLT-2)

**Classification of Neuropsychological Test Scores\***

Classification	Standard Dev (z)	t-score	Scaled Score	Percentile Rank
Superior	≥ 1.1	≥ 61	≥ 14	≥ 85
High average	+0.71 to +1.0	58 - 60	13	76 - 84
Average	-0.70 to +0.70	43 - 57	8 - 12	25 - 75
Low average	-0.71 to -1.0	40 - 42	7	16 - 24
Borderline area	-1.49 to -1.1	36 - 39	6	7 - 15
Well below average	≤ -1.5 to -1.9	≤ 31	≤ 5	≤ 6

\* Please note that the above represents a simple classification table proposed by the examiner to help the reader better understand different scores. This does not reflect a standard method and will differ from that proposed by other neuropsychologists/psychologists.