

Attending Physician's Initial Statement of Disability



The patient must pay any costs for completion of this form.

To the Attending Physician

Please read the following instructions before completing this form.

Do not separate the pages of this claim statement.

Authorizations to release information can be found on pages 8 and 9.

Clearly print or type this form. Fully complete each applicable section of this form. Review the attached Job Description and Training, Education and Experience sections before completing the last page of this form. The Job Description is Part 2 of the Employer's Claim Statement, and the Training, Education and Experience section is Part 2 of the Claimant's Statement.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

Name of patient _____		Date of birth _____	Social Security number _____
History	Patient's symptoms result from <i>(Check all that apply)</i> : <input type="checkbox"/> Employment <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Pregnancy		
	If pregnancy, <i>(expected/actual delivery date)</i> _____ Type of delivery _____		
	Date symptoms first appeared _____ Patient's height _____ Weight _____		
	Name(s), address(es), specialty(ies) of other treating or referring physician(s) _____		
	First visit for this condition _____ Most recent visit _____ Most recent comprehensive exam _____		
Hospital name _____ Confinement dates _____ thru _____			
Diagnoses	Diagnoses with ICD9-CM codes: list in descending order of severity <i>(including any complications)</i> . Please go to the appropriate assessment section and elaborate. ICD9 _____		
	Subjective symptoms _____		
	Objective findings _____		
Attach medical records which document the above diagnostics. <i>(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans)</i>			
Functional Assessment	In terms of an 8 hour day: <input type="checkbox"/> Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently. <input type="checkbox"/> Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently. <input type="checkbox"/> Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently. <input type="checkbox"/> Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting. <input type="checkbox"/> Class 5—Severe limitation; incapable of minimal activity or sedentary* work. <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <small>*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles</small>		
	Please fully describe the patient's capabilities: *With allowance for positional change. N =Never O =Occasionally (1/4–2 1/2 hours) F =Frequently (2 1/2–5 1/2 hours) C =Continuously (5 1/2–8 hours)		
	_____ Standing* _____ Sitting* _____ Walking* _____ Driving* _____ Bending* _____ Data Entry*		
	Lifting not more than _____ pounds _____ (how often) Carry not more than _____ pounds _____ (how often)		
	When did these capabilities begin? _____		
Do you anticipate an increase in your patient's functional capabilities? If so, what date _____			

DO NOT SEPARATE

Treatment	<p>Describe treatment program and give dates of any surgery, medications (dosages/administration routine), physical therapy or psychotherapy.</p> <p>Frequency of treatment and/or symptoms: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (<i>Specify</i>) _____</p> <p>Next scheduled visit _____</p>
Cardiac	<p>Complete only if applicable.</p> <p>Functional capacity (American Heart Association) <input type="checkbox"/> Class 1 (<i>no limitation</i>) <input type="checkbox"/> Class 2 (<i>slight limitation</i>) <input type="checkbox"/> Class 3 (<i>marked limitation</i>) <input type="checkbox"/> Class 4 (<i>complete limitation</i>)</p> <p>Blood pressure (latest reading) _____ as of (date) _____</p> <p>METS level _____ Date _____ Ejection fraction _____ % Date _____</p> <p>Is patient in a cardiac rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," please include dates. Start _____ End _____</p>
Psychiatric Assessment	<p>List the patient's DSM-IV Axes: I _____ II _____ III _____ IV _____ V _____ Date _____ Highest GAF in past year _____ Date _____</p> <p>Please define stress as it applies to this patient.</p> <p>What stress and problems in interpersonal relations has patient had on the job?</p> <p>Please fully describe the patient's limitations.</p> <p>When did these limitations apply? Began _____ Anticipated reduction _____ Anticipated end date _____</p> <p>Do you believe a legal guardian or conservator should be appointed for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Rehab	<p>Is patient a candidate for vocational rehabilitation services? <input type="checkbox"/> Yes (<i>Describe.</i>) <input type="checkbox"/> No (<i>Explain.</i>)</p> <p>Describe any job modifications that would aid your patient in performing his/her work tasks.</p> <p>Has patient reached maximum medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," when? _____ <input type="checkbox"/> Unknown</p>
Name	<p>Physician's name _____ Degree _____ Specialty/Board certification _____</p> <p>Address _____ STREET CITY STATE ZIP CODE</p> <p>Telephone no. _____ Fax no. _____</p> <p>Signature _____ Date _____ DO NOT PRE-DATE PHYSICIAN'S EIN OR SSN</p>

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