Attending physician's statement

1231 East Beltline NE • MS 2260 • Grand Rapids, MI 49525-4501 • Fax: 616 464-8501

SECTION 1 - PATIENT INFORMATION

Name of Patient	Date of Birth	Social Security Number
	/ /	

SECTION 2 - HISTORY

When did symptoms first appear or accident happen?	Date you advised your patient to stop working?	Has patient ever had same or similar condition?	If yes, state when and describe:
/ /	/ /	❑ Yes ❑ No	

Is condition due to or exacerbated by injury or sickness arising out of patient employment?	Name and address of other treating physicians
❑ Yes ❑ No ❑ Unknown	

SECTION 3 - DIAGNOSIS

Date of last examination	Diagnosis (including any complications) Include ICD9	Subjective Symptoms
/ /		

Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings)

If pregnancy, expected delivery date: / /

If delivered, actual delivery date: / /

SECTION 4 - TREATMENT

Date of first visit for this illness or injury	Date of last visit	Date of next visit	Frequency of visits
/ /	/ /	/ /	

Nature of treatment (including surgery and medications prescribed, if any)

SECTION 5 - PROGRESS

Has patient

❑ Recovered ❑ Improved ❑ Unchanged ❑ Retrogressed

If unchanged or retrogressed, please explain:

Is patient

❑ Ambulatory ❑ Bed confined ❑ House confined ❑ Hospital confined

When will patient recover?

Patient's Occupation________________________ ❑ 1 mo. ❑ 1-3 mos. ❑ 3-6 mos. ❑ Never

Any other work____________________________ ❑ 1 mo. ❑ 1-3 mos. ❑ 3-6 mos. ❑ Never

Has patient been admitted to a hospital?

❑ Yes ❑ No

Confined from______________________to______________________

If "Yes" give name and address of hospital

Cardiac (if applicable)

Functional Capacity

(American Heart Assn.) ❑ Class 1 (no limitation) ❑ Class 3 (marked limitation)

❑ Class 2 (slight limitation) ❑ Class 4 (complete limitation)

Therapeutic Class (Activity)

❑ A (no restric.) ❑ C (moderate restric.)

❑ B (slight restric.) ❑ D (marked restric.)

❑ E (complete restric.)

Blood pressure last visit

____

Systolic/Diastolic

Physical Impairment (* As defined in federal dictionary of occupational titles)

❑ Class 1 - No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%)

❑ Class 2 - Medium manual activity* (15-30%)

❑ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)

❑ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)

❑ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)

Remarks:

Mental Impairment (if applicable)

(a) Please define "stress" as it applies to this claimant.

(b) What stress and problems in interpersonal relations has claimant had on job?

❑ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)

❑ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)

❑ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)

❑ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)

❑ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ❑ Yes ❑ No

SECTION 6 - PROGNOSIS

Does patient currently have limitations/restrictions?

Patient's Occupation: ❑ Yes ❑ No

Any Other Work: ❑ Yes ❑ No

Describe specific limitations and restrictions

If employer is able to accommodate patient's limitations and restrictions, is the patient able to return to work?

❑ Yes ❑ No ❑ Part time ❑ Full time

What date could employment begin? / /

Under what conditions can this patient return to work? Please elaborate.

SECTION 7 - PHYSICIAN INFORMATION

Are you, the physician, related to this patient? ❑ Yes ❑ No If "Yes" what is the relationship?

Name (attending physician)		Degree & Specialty		Telephone Number ( )
Street Address	City or Town	State or Province	Zip Code	Fax Number ( )
Tax I.D. Number	Signature X	Date / /		