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Attending Physician's
Statement of Continued Disability
(Short-Term Disability)

Please print or type

To be completed by the Employee

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Employer: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

I hereby authorize release of information on this form by the below-named physician for the purpose of claim processing.

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

To be completed by the Attending Physician - Use current information from your patient's most recent examination or office visit to complete this form. (The patient is responsible for completion of this form without expense to the company.)

DIAGNOSIS

Primary Dx: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Secondary Dx: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Was surgery performed? [ ] Yes [ ] No If Yes, Date: \_\_\_\_\_ Procedure: \_\_\_\_\_ CPT-4 Code: \_\_\_\_\_

Was patient hospitalized since last report? [ ] Yes [ ] No If Yes, Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Current Subjective Symptoms: \_\_\_\_\_

Current Physical Exam Findings: \_\_\_\_\_

Tests (not previously reported): \_\_\_\_\_ Dates: \_\_\_\_\_

Results (or enclose copies of test result report): \_\_\_\_\_

Medication (indicate any changes): \_\_\_\_\_

FUNCTIONALITY (This information is required for evaluation of your patient's claim for disability benefits.)

List all restrictions and/or limitations based on medical findings: (Example - No standing over 4 hours; No lifting over 50 pounds.)

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Is your patient able to work without restrictions? [ ] Yes [ ] No If Yes, Date: \_\_\_\_\_ [ ] Full-time [ ] Part-time for \_\_\_\_\_ hours per day

Is your patient able to return to work with restrictions? [ ] Yes [ ] No If Yes, Date: \_\_\_\_\_ [ ] Full-time [ ] Part-time for \_\_\_\_\_ hours per day

If able to return to work only part-time, on what date will he/she be able to increase to full-time? \_\_\_\_\_

How long are these restrictions expected to be in place? \_\_\_\_\_

TREATMENT

Changes in Treatment Plan: \_\_\_\_\_ No change [ ] Frequency/Duration \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_ Date of Last Office Visit: \_\_\_\_\_ Date of Next Scheduled Office Visit: \_\_\_\_\_

Has patient been referred to other physicians? [ ] Yes [ ] No If Yes, Date of Referral(s): \_\_\_\_\_

Referral Provider Name and Phone #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Referral Provider Name and Phone #: \_\_\_\_\_ Specialty: \_\_\_\_\_

PHYSICIAN INFORMATION

Provider's Name: \_\_\_\_\_ License #: \_\_\_\_\_ SS# or EIN# \_\_\_\_\_

Degree: \_\_\_\_\_ Specialty: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax# \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_