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Attending Physician's
Statement of Functionality

Please print or type

To be completed by the Employee

Patient Name Social Security Number Date of Birth

Employer Name

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

Signed (Patient) Date

To be completed by the Attending Physician (The patient is responsible for the completion of this form without expense to the company)

Please note: Completion of this entire form will allow us to better assess your patient's disability claim.

Patient's condition is the result of: Illness Injury Pregnancy

If pregnancy, what is the expected date of delivery? Month Day Year

Is condition due to illness or an injury that is work-related? Yes No

DIAGNOSIS

Primary diagnosis: ICD-9 Code(s):

Secondary diagnosis: ICD-9 Code(s):

Subjective symptoms:

Blood pressure: Date BP taken: Height Weight

Pertinent test results (list all results, or enclose test):

Test: Date: Results:

Test: Date: Results:

Physical examination findings:

Current medications, dosage, and frequency:

TREATMENTS

Date your patient reported stopped work:

Date you first treated this patient: Date you first treated this patient for this condition:

Date of onset of this condition: Date of most recent treatment:

How often has patient been seen/treated? Date of next office visit:

Has patient been referred to any other physician? Yes No If "Yes," date(s):

Name of physician(s):

Telephone number(s) of physician(s) Specialty:

Has surgery been performed? Yes No Is surgery planned? Yes No

If "Yes," Date: Procedure: CPT Code:

Was patient hospitalized for this condition? Yes No

If "Yes," name of hospital: Telephone number of hospital:

Date(s) admitted: Date(s) discharged:

FUNCTIONAL CAPABILITIES

Please complete this section based on your clinical assessment at the time patient stopped working or reduced work schedule.

In a general workplace environment, the patient is able to:

	Sit	Stand	Walk
# hours at a time			
Total hours/day			

Please check the frequency with which the patient can perform the following activities:

R=Right L=Left B=Bilateral	Never	Occasionally (1-33%)	Frequently (34-67%)	No Restrictions	Not Applicable
Lift/carry 1 to 10 lbs.	R L B	R L B	R L B	R L B	R L B
Lift/carry 11 to 20 lbs.	R L B	R L B	R L B	R L B	R L B
Lift/carry 21 to 50 lbs.	R L B	R L B	R L B	R L B	R L B
Lift/carry 51 to 100 lbs.	R L B	R L B	R L B	R L B	R L B
Lift/carry over 100 lbs.	R L B	R L B	R L B	R L B	R L B
Fingering/handling	R L B	R L B	R L B	R L B	R L B
Bending at waist					
Kneeling/stooping					
Driving					
Reaching only (not load-bearing)	Above shoulder	R L B	R L B	R L B	R L B
	At waist/desk level	R L B	R L B	R L B	R L B
	Below waist/desk level	R L B	R L B	R L B	R L B

Hand dominance: R L

Is the patient's vision impaired? Yes No

Best corrected visual acuity: R _____ L _____

Does the patient have a psychiatric/cognitive impairment? Yes No If "Yes," please describe the extent of the impairment and its etiology: _____

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

Current restrictions or limitations, if different from above: Improved Retrogressed Unchanged

Expected duration of any current restriction(s) or limitation(s) listed above: _____

Can the patient participate in vocational rehabilitation services? (This may include worksite accommodations, identifying alternative work, and/or retraining assistance.)

Yes No If "No," anticipated date they can participate: _____

PHYSICIAN'S INFORMATION

Attending Physician's Name: _____ Telephone Number: _____
(Please print or type)

License # _____ E.I.N.#: _____ Fax #: _____

Degree: _____ Speciality: _____

Address: _____

Signature: _____ Date: _____