THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM.

Part 3—To be completed by Attending Physician *(Please print or type. If necessary, attach separate sheet.)*

History

Patient Name _____ Date of birth _____

Patient's symptoms result from *(Check all that apply.)*:

☐ Employment ☐ Illness ☐ Auto accident ☐ Other accident ☐ Pregnancy _____ (EXPECTED/ACTUAL DELIVERY DATE) Type of delivery _____

Date symptoms first appeared _____

Please fully describe the patient's limitations. _____

When did these limitations apply? Patient's height _____ weight _____

Began _____ Anticipated reduction _____ Anticipated end date _____

Name(s) and address(es) of other treating physician(s) _____

_____

Hospital name _____ Confinement dates _____ thru _____

Diagnoses

Diagnoses with ICD9-CM codes: list in descending order of severity *(including any complications)*. Please go to the appropriate assessment section and elaborate. ICD9 _____ _____ _____ _____

Subjective symptoms _____

Objective findings _____

Attach medical records which document the above diagnostics. *(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans.)*

Do you believe a legal guardian or conservator should be appointed for this patient? ☐ Yes ☐ No

Functional Assessment

In terms of an 8 hour day:

☐ Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently.
☐ Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently.
☐ Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently.
☐ Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting.
☐ Class 5—Severe limitation; incapable of minimal activity or sedentary* work. ☐ Bed confined ☐ House confined

*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles

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? ☐ Yes ☐ No If "Yes," what date? _____

Treatment

First visit for this condition _____ Most recent visit _____ Most recent comprehensive exam _____

Describe the treatment program and give dates of any surgery, medications (dosages/administrations routine), physical therapy or psychotherapy. _____

Frequency of treatment: ☐ Weekly ☐ Monthly ☐ Other *(Specify.)* _____

Psychiatric Assessment

List the patient's DSM-IV Axes: I _____ II _____

Current GAF _____ Date _____ Highest GAF in past year _____ Date _____

Please define stress as it applies to this patient.

_____

What stress and problems in interpersonal relations has patient had on the job?

_____

Please fully describe the patient's limitations.

Rehab

Is patient a candidate for vocational rehabilitation services? ☐ Yes *(Describe.)* ☐ No *(Explain.)*

Name

Physician's name _____ Degree _____ Specialty/Board certification _____

Address _____ (STREET / CITY / STATE / ZIP CODE)

Telephone no. _____ Fax no. _____

Signature _____ Date _____ (DO NOT PRE-DATE) _____ (PHYSICIAN'S EIN OR SSN)