

Disability RMS

Committed to a higher standard



Please return completed form to:

Disability Reinsurance Management Services, Inc.

One Riverfront Plaza

Westbrook, ME 04092-9700

Phone: (877) 254-0085

Fax: (207) 591-3048

Please Return By: _____

ATTENDING PHYSICIAN'S STATEMENT

THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

Patient's Name: _____

Date of Birth: _____

1. HISTORY

- a. When did symptoms first appear or accident happen?
- b. Date patient ceased work because of disability
- c. Is condition a result of patient's employment?
- d. Is condition due to a motor vehicle accident?
- e. Has patient ever had a same or similar condition? (If yes, please describe.)
- f. Names and addresses of other treating physicians:

Date: _____

Date: _____

Yes No

Yes No

Yes No

- g. Have you ever treated patient prior to this? (If yes, for what and when?)

Yes No

- h. Does patient have other disability coverage? (If yes, please identify.)

Yes No

2. DIAGNOSIS

- a. Diagnosis (including any complications):
- b. Subjective symptoms:
- c. Objective findings (include current X-rays, EKG's, laboratory data and any clinical data):

3. DATES OF TREATMENT

- a. Date of first visit Date: _____
- b. Date of last visit Date: _____
- c. Frequency: Weekly Monthly Other(specify)

4. NATURE OF TREATMENT(surgery, medications, etc.)

5. EXTENT OF DISABILITY

IMPORTANT

- a. Are you aware of the main duties the patient performs in his/her usual work or business? Yes No
- b. Are you aware of the patient's background (education, training, experience, etc.)? Yes No

Describe any restrictions (what your patient should not do):

Describe any limitations (what your patient cannot do):

6. CARDIAC (if applicable)

- a. Functional Capacity (American Heart Association): Class 1 (No Limitation) Class 3 (Marked Limitation)
 Class 2 (Slight Limitation) Class 4 (Complete Limitation)

- b. Blood Pressure (last visit):

_____/_____
Systolic Diastolic

7. 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 capability; capable of clerical/administrative (sedentary) activity* (60-70%)
- Class 5 -- Severe limitation of functional capacity; incapable of minimal (sedentary) activity* (75-100%)
- Remarks:

8. MENTAL/NERVOUS IMPAIRMENT (If applicable)

- Class 1 -- Patient able to function under stress and able to engage in interpersonal relations (No limitations).
- Class 2 -- Patient able to function in most stress situations and engage in limited interpersonal relations (Slight Limitation).
- Class 3 -- Patient able to engage in only limited stress situations and engage in limited interpersonal relations (Moderate limitation).
- Class 4 -- Patient unable to engage in stress situations or engage in interpersonal relations (Marked limitation).
- Class 5 -- Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitation).
- Remarks:

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

9. PROGRESS

- a. Has patient Recovered? Improved? Unchanged? Regressed?
 If recovered, date patient able to work: Date: _____
- b. Is patient Ambulatory? House confined? Bed confined? Hospital confined?
 Yes No
- c. Has patient been hospital confined?
 Admitted _____ Discharged _____

Please give name and address of hospital:

- d. Do you expect any significant improvement in the future? Yes No
- (1) If yes, when will patient recover sufficiently to perform the duties of:
- (a) HIS/HER REGULAR JOB? _____ / _____ / _____ 1 Month 1- 3 Months
 Month Day Year 3- 6 Months Never
- (b) ANY OTHER TYPE OF WORK _____ / _____ / _____ 1 Month 1- 3 Months
 Month Day Year 3- 6 Months Never
- (2) If no, please explain:

e. If you do not expect patient to be able to return to his/her occupation or any other occupation, would you support his/her candidacy for Social Security Disability benefits? Yes No

10. REHABILITATION

- | | PATIENTS JOB | ANY OTHER WORK |
|---|---|---|
| a. Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Can present job be modified to allow for handling with impairment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. When could trial employment commence? | _____ / _____ / _____
mo. day yr.
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time | _____ / _____ / _____
mo. day yr.
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time |
| d. Would vocational counseling and/or retraining be recommended? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

11. REMARKS:

Name of Attending Physician (Print) _____ Degree _____ Telephone _____ Fax _____

Street Address _____ City or Town _____

State _____ Zip Code _____

Signature _____ Date _____