Disability Claim Form

PHYSICIAN FORM

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1. Name of Patient	2. SSN	3. Gender ☐ Male ☐ Female	4. DOB

History

a) Date symptoms first appeared or illness/accident happened	b) Date you advised patient to stop working	c) Has patient ever had same or similar condition? ☐ Yes ☐ No *If yes, attach description and dates*
d) Is condition due to injury or sickness arising out of patient's unemployment? ☐ Yes ☐ No ☐ Unknown	e) Names and addresses of other treating physicians	

Diagnosis

a) Date of last exam	b) Primary Diagnosis (including any complications)	c) ICD9 Code
d) Subjective Symptoms		

e) Secondary Diagnosis (if applicable)	f) ICD9 Code	g) Subjective Symptoms

h) Objective findings (including current x-rays, EKG's, lab data, and any clinical findings)	i) If pregnant, expected delivery date	j) If delivered, actual delivery date

Treatment

a) Date of first visit for this illness or injury	b) Date of last visit	c) Date of next visit	d) Frequency of visits

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

f) Is patient: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

g) Has patient been hospital confined? ☐ Yes ☐ No If yes, when? _______________ to _________________

Hospital Name: ____ Expected Recovery Date: __________________________

Hospital Address: ____

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Additional Remarks:

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Cardiac (if applicable)
a) Functional Capacity (American Heart Assn.)
☐ Class 1 (no limitation)
☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation)
☐ Class 4 (complete limitation)

b) Therapeutic Class (Activity Restriction)
☐ A. (none) ☐ B. (slight)
☐ C. (moderate) ☐ D. (marked)
☐ E. (complete)

c) Blood pressure last visit
____
Systolic/Diastolic

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

REMARKS:

☐ 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%)

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

REMARKS:

a) Does patient currently have limitations/restrictions?
Patient's Occupation: ☐ Yes ☐ No
Any Other Work: ☐ Yes ☐ No

b) Describe specific limitations and restrictions:

c) If employer can accommodate limitations and restrictions, is this patient able to return to work?
☐ Yes ☐ No ☐ Part-Time ☐ Full-Time

d) Date employment could begin

e) Under what conditions could this employee return to work? Please elaborate.

Are you, the physician, related to this patient? ☐ Yes ☐ No If yes, what is the relationship? ___________
____

NOTE: If there are multiple unrelated diagnoses, please complete a second physician form with all relevant information.

ADDITIONAL REMARKS:

____
Name (attending physician) Please Print Degree Phone Number

____
Street Address City State Zip Fax Number

Tax ID #: ________________ Physician Signature: ________________________________ Date: ________________