Physician Update In Status Form

Mail To: **CompuSys/Erisa Group, Inc.**
OR FAX **13706 Research Blvd. Suite 308, Austin TX 78750**

Claim Questions: 1-800-933-7472 **FAX TO: (512) 597-4692**

Name of Patient	Date of Birth / /	Social Security Number - -

In your opinion, what is the diagnosis and prognosis of the patient's condition?

In your opinion, do you think the patient will recover from this illness or injury? If so, when?

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

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

Progress

a) Has patient
□ Recovered □ Improved □ Unchanged □ Retrogressed

b) Is patient □ Ambulatory □ Bed Confined
□ House Confined □ Hospital Confined

c) If unchanged or retrogressed, please explain:

d) Has patient been hospital confined? □ Yes □ No

confined from_____ to _____

If "Yes", give name and address of hospital

If you do not do impairment ratings, please give us enough information on the first two questions above to be able to evaluate as appropriate.

a) Cardiac (if applicable) Functional Capacity (AHA)
□ Class 1 (no limitation)
□ Class 2 (slight limitation)
□ Class 3 (marked limitation)
□ Class 4 (complete limitation)

b) **Therapeutic Class (Activity)**
□ A (no restric.)
□ B (slight restric.)
□ C (moderate restric.)
□ D (marked restric.)
□ E (complete restric

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 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 engage in only 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:

Prognosis

a) Does patient currently have limitations/restrictions?

Patients Occupation: □Yes □No

Any Other Work □Yes □No

b) Describe specific limitations and restrictions

c) If employer is able to accommodate patient's limitations and restrictions, is this patient able to return to work?

d) □Yes □No □Part Time □Full Time

e) What date could employment begin?

/ /

f) Under what conditions can this patient return to work? Please elaborate.

Are you the physician, related to this patient? □Yes □No If "Yes", what is the relationship?

Printed Name of Attending Physician **Degree/Specialty**

>

Telephone Number
( ) --

Street Address/PO Box **City or Town** **State** **Zip Code**

>

Fax Number
( ) --

Tax I.D. Number

>

PHYSICIAN'S SIGNATURE

X

Date: / /