Attending Physician's Statement – Progress Report

The patient is responsible for completion of this form without expense to the company

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Condition Please complete this form based upon the most recent patient contact/evaluation

Projected full time return to work date: _ _/_ _/_ _ _ _ (MM DD YYYY)

Office visit to complete this form: _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ In Person ☐ Telemedicine

If pregnancy, what is date of delivery? _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ Actual ☐ Estimated

Current Disabling Diagnosis(es) and Impact to Function

ICD 10 Codes
Please provide most specific codes:

|__||__||__|.|__||__||__||__| \ |__||__||__|.|__||__||__||__|

Description of corresponding symptoms and clinical exam findings:

____

____

Co-Morbid Conditions with Impact to Diagnosis

☐ None ☐ Opioid Usage ☐ Psoriasis ☐ Mental Health

☐ Diabetes ☐ Heart Disease ☐ Asthma/Bronchitis ☐ Cognitive Impairment

☐ Hypertension ☐ Obesity ☐ Auto-Immune Disease

☐ COPD ☐ Arthritis ☐ Other ____________

In your opinion is the patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Treatment Plan

☐ Conservative treatment ☐ Bed Rest ☐ Palliative care ☐ Hospice Care

☐ Hospitalization Admittance date: _ _/_ _/_ _ _ _ (MM DD YYYY) Discharge date: _ _/_ _/_ _ _ _ (MM DD YYYY)

☐ Next/Another appointment Date: _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ In Person ☐ Telemedicine

☐ Physical/Occupational therapy |__| times per week ☐ until _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ Actual ☐ Estimated

☐ Surgery Date: _ _/_ _/_ _ _ _ (MM DD YYYY) CPT Code(s): |__||__||__||__||__| \ |__||__||__||__||__|

☐ Referral to a specialist Type: _________________________ Contact Info:_________________________________

Current Medications (related to condition or impacting function)

☐ None ☐ Over counter medications: ____

☐ Prescription medications Name(s): ____

☐ Impacting function? ☐ Yes ☐ No If yes, why? ____

☐ Chemotherapy ☐ Radiation Start Date: _ _/_ _/_ _ _ _ (MM DD YYYY) End Date: _ _/_ _/_ _ _ _ (MM DD YYYY)

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Level of Functionality (Based upon your medical findings and opinion, address the full range of your patient's abilities. We will conclude that there are no restrictions on function unless specified below.)

Expected duration of any restriction(s) or limitation(s) listed below THROUGH __/__/____ MM DD YYYY

In a workday the patient is able to: (select either Continuous or Intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent, enter time for each section below	
				Hours at one time	Total hours in a workday
Sit	☐	or	☐	|___|	|___|
Stand	☐	or	☐	|___|	|___|
Walk	☐	or	☐	|___|	|___|

Key: C = Continuously (5.5 – 8 hours) F = Frequently (2.5 – 5.5 hours) O = Occasionally (up to 2.5 hours) N = Never

Activity Ability	C	F	O	N	Activity Ability	Right/Left	C	F	O	N
☐ Drive	☐	☐	☐	☐	☐ Squat/Kneel		☐	☐	☐	☐
☐ Weight bearing	☐	☐	☐	☐	Hand Dominance	☐ R ☐ L				
☐ Climb	☐	☐	☐	☐	☐ Fine Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐ Gross Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Max lift	____LBS	____LBS	____LBS	____LBS	☐ Reach above shoulder	☐ R ☐ L	☐	☐	☐	☐
☐ Max carry	____LBS	____LBS	____LBS	____LBS	☐ Reach below shoulder	☐ R ☐ L	☐	☐	☐	☐

Completed or Planned Diagnostic Tests, Labs and Imaging (related to the disabling diagnosis)

Completed: ☐ X-ray __/__/____ MM DD YYYY ☐ MRI __/__/____ MM DD YYYY ☐ CT __/__/____ MM DD YYYY ☐ EKG __/__/____ MM DD YYYY

☐ ECHO __/__/____ MM DD YYYY ☐ EMG __/__/____ MM DD YYYY ☐ Lab Work __/__/____ MM DD YYYY

Findings of completed tests: ☐ No significant findings ☐ Confirmed diagnosis

Planned: ☐ X-ray ☐ MRI ☐ CT ☐ EKG ☐ ECHO ☐ EMG ☐ Lab Work Scheduled date __/__/____ MM DD YYYY

Provider Details

Provider Name: ______________________________

Specialty: ______________________________

EIN Number: ______________________________

License Number: ______________________________

Email: ________________________

Phone: (___) ___-____

Fax: (___) ___-____

Provider Signature: ____

Date: __/__/____ MM DD YYYY