



Acumen Medical Practice
 791 North Lane
 Somewhere, OR 12345
 555-888-8888

OFFICE OF STATE EMPLOYER
Attending Physician's Statement

Patient Information

Name:

Social Security #

Medical Record #

Address (Street, City, State)

Current Department

Agency

I hereby authorize any agency of the State of Oregon insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the information given by me in support of this claim is true and correct.

Date

Signature:

History

When did symptoms first appear or when did the accident happen?

DD/MM/YYYY

Date doctor authorized patient to cease work because of disability:

DD/MM/YYYY

Has patient ever had same or similar condition? Yes No

If yes, state when and describe:

Present Condition

Subjective symptoms:

Is the condition due to injury or sickness arising out of the patient's employment?

Yes

No

If 'yes,' please explain:

Objective findings (include results of current X-rays, EKG's or any other special test:

Is patient...

Restrictions/Limitations:

Ambulatory

Bed Confined

House Confined

Hospital Confined

Contagious

On Narcotic Medication

Diagnosis

Diagnosis:

ICD 9:

ICD 10:

Name of Hospital

Anticipated Length of Hospitalization

Surgical Procedure:

Date of Surgery:

If Pregnancy, date of LMC

EDC Date:

Delivery Date

Treatment

Date of first visit for this period of disability:

DD/MM/YYYY

Frequency of Visits

Weekly

Monthly

Other

When did you last examine or treat the patient?

DD/MM/YYYY

Date of next scheduled visit:

DD/MM/YYYY

Progress...

Recovered:

Improved:

Unimproved:

Extent of Disability

Is patient now totally disabled?

For any occupation:

For usual occupation:

Yes

Yes

No

No

If no, when was patient able to go to work?

For any occupation:

For usual occupation:

If yes, when do you think the patient will be able to resume any work?

For any occupation:

For usual occupation:

If yes, is patient a suitable candidate for a return to work program?

Yes

No

Is the patient competent to endorse the checks and direct the proceeds thereof?

Yes

No

If yes, please complete the appropriate return to work assessment form.

Print Name:

Address:

City, St.:

Zip:

Signature (Attending Physician/Mental/Health Provider):

Date

Phone #:

Degree: