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…

- ☐ Ambulatory
- ☐ Bed Confined
- ☐ House Confined
- ☐ Hospital Confined
- ☐ Contagious
- ☐ On Narcotic Medication

Restrictions/Limitations:

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:
- ◯ Yes
- ◯ No

For usual occupation:
- ◯ Yes
- ◯ 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: _____