



P.O. Box 14192, Lexington, KY 40512-1192
Telephone: 800-638-4228 Facsimile: 859-264-4384 Email: myclaimdocs@sedgwick.com

Attending Physician Statement
To be completed by physician

Patient's Name: _____

Date of Birth: _____

Claim Number: _____

Medical Due Date: _____

1. Objective findings: HT: _____ WT: _____ BP: _____ TEMP: _____ PULSE: _____ RESP: _____

2. Patient's Complaints: _____

3. Your Diagnosis: (list all disabling diagnoses including all ICD codes)

Primary: ICD Code: _____ Description: _____

Secondary: ICD Code: _____ Description: _____

4. Describe objective/clinical findings to warrant disability, including severity and duration based on the patient's presentation during office visits. _____

5. When was patient first diagnosed with this condition? ____/____/____

List all medications, identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Adjusted
_____				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	____/____/____
_____				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	____/____/____
_____				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	____/____/____
_____				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	____/____/____

6. Is this condition the result of an injury? Yes No Is this condition work related? Yes No If yes, provide date and description of event: _____

List all co-morbid conditions: _____

7. If patient is pregnant, indicate estimated date of delivery ____/____/____

8. Is a C-Section planned? Yes No If yes, date scheduled: ____/____/____

9. Give all dates of treatments by you during this period of disability; also indicate date of follow up visit: _____

10. What is the prescribed treatment plan? (please provide specific details regarding treatment/therapy, attach notes if necessary):

11. Have there been any Emergency Room visits OR Hospitalizations during this current disability period? Yes No

If Yes: Emergency Room visit Hospitalization 23 hour admission

Name and address of hospital or facility _____

Date of admission: ____/____/____ Date of discharge: ____/____/____

Indicate treatment provided: _____

12. Has any surgical procedure related to current disability been performed or is any anticipated? Yes No

List the name of the procedure: _____

CPT code: _____

Date of procedure: ____/____/____

13. Has patient been referred to other physician(s)/specialist? Yes No If yes, provide physician name, specialty, and telephone number. _____

14. List specific functional limitations of Activities of Daily Living (ADL's): _____

15. Has patient been given any driving restrictions for this disability period? Yes No

If yes please describe: _____

16. Based on your personal knowledge and treatment, how long has the patient been totally disabled by this sickness and prevented from working? From ____/____/____ to and including ____/____/____

17. Has the patient recovered sufficiently to return to work? Yes No

If yes, give the date the patient was able to return to work ____/____/____

If no, in your opinion when, may work be resumed? (please do not use "indefinite", "unknown", "undetermined", etc.) If a date cannot be determined, please estimate in days, weeks or months, the total duration of disability. ____/____/____

18. Has the patient recovered sufficiently to return to restricted work? Yes No

If yes, indicate date restrictions begin: ____/____/____ date restrictions end: ____/____/____

Restriction (s) required: _____

Attach if relevant all office notes, history & physical, results of x-rays, laboratory tests, MRI Reports, etc.

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Telephone Number: _____

Physician Printed Name: _____

Fax Number: _____

Physician Specialty: _____

Date Completed: _____

Physician Signature: _____