ReedGroup

Attending Physician's Statement of Work Capacity and Impairment

Return completed form to PO Box 6278, Broomfield, CO 80021 or Fax to 1-847-554-1853

Note: Your patient has informed ReedGroup that you would be willing to submit clinical information to support his/her disability claim.

In accordance with the federal law, GINA, [Genetic Information Nondiscrimination Act of 2008], please do not provide us with any genetic information. More information about GINA is included on the Authorization form [employee/patient] presented to you.

Patient Information

First Name: | Last Name: | Claim Number:

Date of Birth ____/____/____ | Gender: ☐ Male ☐ Female | Record Number:

Vocational Information

Employer: | Job Title: | Date of Hire: ____/____/____

Physical Demand Level per maximum pounds of exertion:
☐ Sedentary (10 lbs) ☐ Light (20 lbs) ☐ Medium (50 lbs.) ☐ Heavy (100 lbs.) ☐ Very Heavy (greater than 100 lbs.)

Intellectual Skill Demand: ☐ Unskilled ☐ Semi-skilled ☐ Skilled ☐ Highly Skilled

Claim Information

First day of absence: ____/____/____ | Definition of Disability: ☐ Own Job ☐ Own Occupation ☐ Any Occupation

Claim Manager: | Phone Number & Ext: | Fax Number:

1. Nature of Treatment & Work Capacity Evaluation

Primary Diagnosis: _____ ICD-10 or DSM code(s): _____

Secondary/Co-morbid Diagnosis impacting work: _____ ICD-10 or DSM code(s): _____

Tertiary/Co-morbid Diagnosis impacting work: _____ ICD-10 or DSM code(s): _____

Onset of primary condition: ____/____/____

- Hospital stay: ☐ Not applicable Admitted on: ____/____/____ Discharged from Hospital on: ____/____/____
- Recent Surgery Date: ____/____/____ Type of Surgery: _____

Name and Address of Hospital:_____

- Medications-name /dosage/frequency: _____
- Other treatment methods: _____

1.) Is the patient's primary condition due to injury or illness arising out of the patient's employment? ☐ No ☐ Yes ☐ Unknown

Contact information for other health care providers treating this patient: ☐ Not applicable

Name: _____ Phone: _____ Address: _____

Name: _____ Phone: _____ Address: _____

2.) Did you recommend that your patient stay home from work? ☐ No ☐ Yes, on the following date ____/____/____

If no, please complete sections 2-3 and provide a work release per section 5, question 6.

If yes, please provide your rationale for recommending disability leave by referencing the patient's signs and symptoms and their relation to functional impairment(s) that precluded work. Please be sure to explain how this patient's impairment impacted his capacity to perform the physical and/or intellectual demands of his/her job per the definition of disability noted above. If the disability 'test" is noted to be "Any Occupation" please explain how impairment was determined to preclude any work which would include work at the sedentary and unskilled levels.

_____

_____

_____

2. Treatment Plan

Date of first office visit: / / | Date of last office visit: / / | Next office visit: / / _

Expected Treatment Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify)_____

(a) Is this patient still under your care for the primary disabling condition?
☐ Yes ☐ No, indicate date service terminated: ____/____/____ or referred ____/____/____

(b) If patient has been referred to a specialist, please list the Provider's Name and Phone number
_____

Is surgery planned? ☐ No ☐ Yes, on ____/____/____Procedure(s): _____
Procedure Code_____

Health Care Provider's Initials: | **Date:**

Any claim adjustment described above for Employees Retirement System of Texas (ERS) is performed by Reed Group Management LLC ("ReedGroup"), a licensed, third-party administrator. ReedGroup is licensed in Texas for the administration of Texas Employees Group Benefits Program ("GBP") according to Chapter 1551, Texas Insurance Code.

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Patient Information	Name	Claim Number

3. Medical Signs and Symptoms

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____ / _____ Date Measured: ____/____/____

Patient's Complaints (symptoms):

_____

_____

_____

Physical Examination Findings:

_____

_____

_____

Diagnostic Test/Study Findings (imaging studies, lab values, functional testing, e.g. pulmonary function tests, cardiac tests, etc.):

_____

_____

_____

If work absence is due to pregnancy, the expected date of delivery is: ____/____/____

4. Mental or Psychiatric Impairment (if applicable)

Please provide your formal Mental Status Exam results and Behavioral Observations.

Affect/Emotional Appropriateness and Control:
☐ WNL ☐ Impaired as evidenced by
_____

Behavioral Appropriateness/Control, Pace & Stamina:
☐ WNL ☐ Impaired as evidenced by
_____

Cognitive Processing/functioning:
☐ WNL ☐ Impaired as evidenced by
_____

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No
If no, please explain:
_____

5. Return to Work Status

1.) Do you **currently** consider your patient to be totally impaired from working? ☐ No ☐ Yes
If yes, as of what date? ____/____/____ **If yes,** as supported by the following rationale citing medical facts documenting my patient's functional impairments and or stage of recovery from a medical procedure which at this time precludes work.

_____

_____

2. What is the **estimated** date of the patient's release to modified duty ____/____/____ and to full duty ____/____/____

3. Are there **currently** any temporary work restrictions and/or accommodations which would allow this patient to return to work?

☐ No ☐ Yes, please specify by providing objective quantification e.g. no lifting greater than 20 lbs.

_____

4. When do you anticipate your patient will reach maximum medical improvement? _____

5. Do you anticipate, or currently recommend, permanent work restrictions? _____

6. Regarding my care of this patient return to work status is as follows:

☐ Released to full duty on ____/____/____

☐ Released to temporary modified duty as describe above on ____/____/____ and to full duty as of ____/____/____

☐ Unable to release patient at this time. I anticipate significant clinical improvement in my patient's functional capacity by the following date:____/____/____

Health Care Provider's Name (print)	Specialty	Degree	Tax ID #
Address (No., Street, City, State, Zip Code)		Phone	Fax
Signature		**Date**	

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