

ATTENDING PHYSICIAN'S STATEMENT

Name of patient _____ Date of birth _____

Employer name _____

1. HISTORY

- (a) When did symptoms first appear or accident happen? Mo. _____ Day _____ 20 _____
- (b) Date patient ceased work because of disability. Mo. _____ Day _____ 20 _____
- (c) Has patient ever had same or similar condition? Yes No If "Yes", state when and describe.
- (d) Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown
- (e) Names and addresses of other treating physicians.
- (f) Has patient been hospital confined? Yes No If yes, give name/address of hospital _____
 Confined from _____ through _____

2. DIAGNOSIS

- (a) Diagnosis (including any complications). ICD-9 Code _____
- (b) Objective findings (including current x-rays, EKG, laboratory data and any clinical findings).
- (c) Subjective symptoms.
- (d) Diagnosis of pregnancy: Date last L.M.P. _____ Date EDC _____ Date delivery _____

3. DATES OF TREATMENT

Remarks

- (a) Date of first visit. Mo. _____ Day _____ 20 _____
- (b) Date of last visit. Mo. _____ Day _____ 20 _____
- (c) Frequency. Weekly Monthly Other (specify) _____

4. NATURE OF TREATMENT (Including Surgery, Rehabilitation and medications prescribed, if any).

6. VOCATIONAL REHABILITATION

(a) Would vocational counseling and/or vocational rehabilitation be recommended? Yes No, Why not?

(b) Would job modification enable patient to work with impairment? Yes No If yes, how?

5. PROGRESS

- (a) Has patient reached Maximum Medical Improvement? Yes No
- (b) If no, when do you expect a fundamental change? Mo ___ Day ___ Year ___
- (c) When will patient recover sufficiently to return to work? Mo ___ Day ___ Year ___

7. CARDIAC (If Applicable)

- (a) Functional capacity (American Heart Ass'n.) Class 1 (No limitation) Class 2 (Slight limitation)
- Class 3 (Marked limitation) Class 4 (Complete limitation)
- (b) Blood Pressure (last visit) _____
 systolic/diastolic

8. FUNCTIONAL LIMITATIONS - ABILITIES

Indicate longest single time duration each activity can be performed.

Indicate frequency per day the listed activity can be performed.	_____ Sitting	_____ Kneeling	_____ R Finger Dexterity	} Reaching
(n - never, o - occasional, f - frequent, c - constant)	_____ Total time on feet		_____ L	
LIFTING	_____ Standing	_____ Inside	_____ R Below Shoulders	
_____ 1-5 lbs.	_____ Walking		_____ L	
_____ 6-10 lbs.	_____ Bending	_____ Outside	_____ R Above Shoulders	
_____ 11-25 lbs.	_____ Squatting	_____ Working with Others	_____ L	
_____ 26-50 lbs.	_____ Stooping	_____ Other (explain) _____		
_____ 51-100 lbs.				
_____ over 100 lbs.				
CARRYING	_____ 1-5 lbs.			
_____ 6-10 lbs.				
_____ 11-25 lbs.				
_____ 26-50 lbs.				
_____ 51-100 lbs.				
_____ over 100 lbs.				

Doctor: Please describe fully how patient's symptoms/limitations affect ability to work, e.g. how are work schedule or duties restricted and why?

9. PSYCHIATRIC IMPAIRMENT (if applicable)

- (a) Please define "stress" as it applies to this claimant.
- (b) What stress and problems in interpersonal relations has claimant had on job?
 - Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
 - Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
 - Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
 - Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
 - Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

10. Doctor: Please include copies of office notes for the period of treatment, test results, available discharge summaries and any consulting physician reports.

Name (Attending Physician) Print	Degree	Telephone
Street Address	City or Town	State or Province
		ZIP Code
Signature	Date	Taxpayer ID Number (EIN)

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

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