alight

Attending Physician's Statement of Work Capacity and Impairment

Return completed form to P.O. Box 1497 Lincolnshire IL 60069 or Fax to 1-847-554-1853

Note: Your patient has informed Alight 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 or her 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.

_____

_____

_____

Is the condition work related? ☐ No ☐ Yes Did you complete a Workers Compensation Claim Form? ☐ No ☐ Yes

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_____		

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 return to work 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 operationalize 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 determine at this time. If unable to determine, do you support the employee remaining off work until their next appointment date listed in section 2"Next Office Visit" ☐ Yes ☐ No

☐ Unable to release patient at this time.

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