



ADA Life and Disability
 P.O. Box 1700
 Denver, CO 80201
 1-800-537-2033

SUPPLEMENTAL ATTENDING PHYSICIAN'S STATEMENT FOR PSYCHOLOGY/PSYCHIATRY

NOTE: Great-West Life & Annuity Insurance Company assumes no responsibility for any expense incurred in the completion of this statement. When completed, mail this statement directly to Great-West Life and Annuity Insurance company or return form to patient.

Please Print

Name of patient _____ Date of birth _____ / _____ / _____
Month Day Year

Patient's address _____
Number Street City State Zip Code

1105/1106/104GP
Plan number

I hereby authorize release of information requested on this form, by the below named physician for the purpose of claim processing.

Signed (Patient) _____
 Date _____

1. History

(a) When did symptoms first appear?..... Mo. _____ Day _____ Year _____

(b) Date patient ceased work because of disability..... Mo. _____ Day _____ Year _____

(c) Has patient ever had same or similar condition? Yes No If "Yes" state when and describe: _____

(d) Names and addresses of other treating physicians: _____

2. Psychological Diagnoses and Symptoms – Please complete this section if the primary or secondary diagnosis involves a psychological or psychiatric condition, or if the patient is suffering from symptoms that are psychological in nature.

(a) DSM-IV Multiaxial Diagnosis
 Axis I _____ Axis II _____
 Axis III _____ Axis IV _____
 Axis V: Current GAF _____ Highest Past Year _____ Baseline _____

(b) Subjective Symptoms: _____

(c) Secondary Diagnosis (include complications): _____

(d) Secondary Subjective Symptoms: _____

(e) How have the subjective symptoms been verified? _____

(f) Objective Findings (**Please attach copies of any testing or clinical findings**): _____

(g) In your opinion do the objective findings support that level of subjective limitations reported by your patient: Yes No
 Please explain your answer: _____

(h) Complete the following checklist. Add explanations if necessary in the space provided below.
 Degree of Impairment (Scale: 0-None; 1-Slight; 2-Moderate; 3-Significant; 4-Severe)

Interpersonal relations	_____
Daily activities-occupational	_____
Daily activities-social	_____
Ability to think and reason	_____
Sustain work performance	_____
Concentration	_____
Present Memory Disturbance	_____
Judgment	_____
Suicidal ideation/intent	_____

3. Dates of Treatment		
(a) Date of first visit.....	Mo. _____	Day _____ Year _____
(b) Date of last visit.....	Mo. _____	Day _____ Year _____
(c) Frequency.....	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify)	
4. Nature of Treatment and medications prescribed, if any:		
5. Progress		
(a) Has patient.....	<input type="checkbox"/> Recovered?	<input type="checkbox"/> Improved? <input type="checkbox"/> Remained unchanged? <input type="checkbox"/> Retrogressed?
(b) Is patient.....	<input type="checkbox"/> Ambulatory?	<input type="checkbox"/> House confined? <input type="checkbox"/> Bed confined? <input type="checkbox"/> Hospital confined?
(c) Has patient been hospital confined?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" give name and address of hospital
_____	Confined from _____	Through _____
6. Current Condition		
(a) Is patient now totally disabled from his/her own occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) Is patient now totally disabled from all occupations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) If not now totally disabled, when was patient able to resume his/her regular duties?	<input type="checkbox"/> Part-time _____/_____/_____ <input type="checkbox"/> Full-time _____/_____/_____	
	If part-time # of hours worked per week _____	
(d) What duties of patient's job is he/she incapable of performing?	_____	
Prognosis		
Do you expect a fundamental or marked change in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(a) If yes, when will patient recover sufficiently to perform his/her regular duties?	<input type="checkbox"/> 1 mo. <input type="checkbox"/> 1-3 mo. <input type="checkbox"/> 3-6 mo. <input type="checkbox"/> Never	
(b) If no, please explain:	_____	
7. Remarks		

Name (Attending Physician) / Please Print	Degree / Specialty	() Telephone
Street Address		() Fax
City or Town	State	Zip Code
Signature *		Date

*** Stamped signature or signature other than physician's own signature will not be accepted.**