



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

## SUPPLEMENTAL ATTENDING PHYSICIAN'S STATEMENT FOR VISION

**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 or accident happen?..... Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

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

(c) Names and addresses of other treating physicians \_\_\_\_\_

**2. Current Findings**

(a) Date of last examination..... Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(b) Current diagnosis(es) (including any complications) \_\_\_\_\_

(c) Describe any pathology resulting in decreased visual acuity or constriction of fields (i.e. funduscopy or retinoscopy findings): \_\_\_\_\_

**3. Dates of Treatment**

(a) Date of first visit..... Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(b) Date of last visit..... Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(c) Frequency.....  Weekly  Monthly  Other (specify) \_\_\_\_\_

**4. Nature of Treatment (including date and type of surgery and medications prescribed, if any)**

\_\_\_\_\_

**5. Progress**

(a) Has patient.....  Recovered?  Improved?  Remained unchanged?  Retrogressed?

(b) Is patient.....  Ambulatory?  House confined?  Bed confined?  Hospital confined?

(c) Has patient been hospital confined?...  Yes  No If "Yes" give name and address of hospital  
 \_\_\_\_\_ Confined from \_\_\_\_\_ Through \_\_\_\_\_

**6. Visual Impairment**

(a) What was vision at last observation?  
 With Glasses..... O.D. \_\_\_\_\_ O.S. \_\_\_\_\_ Mo. \_\_\_\_\_ Day \_\_\_\_\_ 20 \_\_\_\_\_  
 Without Glasses..... O.D. \_\_\_\_\_ O.S. \_\_\_\_\_ Mo. \_\_\_\_\_ Day \_\_\_\_\_ 20 \_\_\_\_\_

(b) If fields of vision are contracted, show construction on chart  
 (c) Date corrected vision was irrecoverably reduced to 20/200 or less in the better eye:

(d) Vision can be restored in whole or in part by :

O.D. Lenses  Treatment  Operation  Not restorable   
 O.S. Lenses  Treatment  Operation  Not restorable

(e) How are the following affected by this patient's condition?

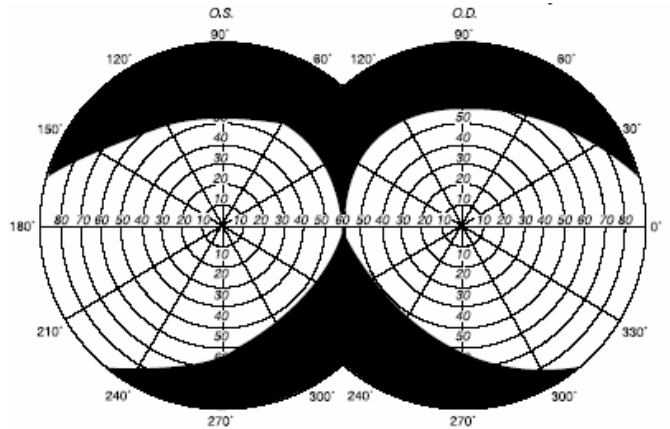
Reading –

Driving –

Tasks requiring visual discrimination –

Depth perception –

Peripheral vision –



Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ O.D.  O.S.

**7. Current Condition**

(a) Is patient now totally disabled from his/her own occupation?  Yes  No  
 (b) Is patient now totally disabled from all occupations?  Yes  No  
 (c) If not now totally disabled, when was patient able to resume his/her regular duties?  
 Part-time \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  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?  Yes  No  
 (a) If yes, when will patient recover sufficiently to perform his/her regular duties?  
 1 mo.  1-3 mo.  3-6 mo.  Never  
 (b) If no, please explain:  
 \_\_\_\_\_

**8. Remarks and current treatment plan:**

\_\_\_\_\_  
 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.**