GREAT-WEST FINANCIAL

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SUPPLEMENTAL ATTENDING PHYSICIAN'S STATEMENT FOR CARDIOLOGY

NOTE: Great-West assumes no responsibility for any expense incurred in the completion of this statement. When completed, please mail or fax this statement directly to Great-West 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) Blood Pressure _____ Pulse _____ Current Weight _____ Height _____

(b) Date of last examination..... Mo. _____ Day _____ Year _____

(c) Please indicate current symptoms by placing a ✓ next to the ones that apply:

Is there chest pain..... ☐ While resting? ☐ With exertion? ☐ Relieved by medication?

Is there shortness of breath? ☐ Yes ☐ No If Yes..... ☐ With exertion only ☐ Orthopnea ☐ Syncope

Is there paroxysmal nocturnal dyspnea? ☐ Yes ☐ No If Yes ☐ Precipitating factors ☐ Palpitations ☐ Generalized weakness and/or malaise and/or fatigue

(d) Please advise frequency of patient's pain, duration, precipitating factors and how it is relieved

(e) Objective findings (including current X-ray Reports, EKGs, laboratory data and any clinical findings)

(f) Diagnosis (including any complications)

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 onfined?..... ☐ Yes ☐ No If "Yes" give name and address of hospital

_____

_____

Date of Admission _____/_____/_____ Date of Discharge _____/_____/_____

6. Cardiac

(a) Functional capacity..... ☐ Class 1 (No limitation) ☐ Class 2 (Sight limitation)

(American Heart Association) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) **Blood pressure** (last visit)..... Systolic _____ /Diastolic _____

7. Physical Impairment (*as defined in US Dept of Labor Dictionary of Occupations Titles) Please offer your recommendations

☐ Class 1 - No limitation of functional capacity; capable of heavy work*.....No restrictions (0-10%)

☐ Class 2 - Medium manual activity*.....(15-30%)

☐ Class 3 - Slight limitation of functional capacity; capable of light work*.....(35-55%)

☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity.....(60-70%)

☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (Sedentary*) activity.....(75-100%)

☐ Remarks:

8. Please provide us with a brief description of your patient's physical limitations:

9. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

10. 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:

_____

11. 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.***