P.O. Box 17410
Denver, CO 80217-0410
1-866-257-0707 – Tel
1-303-737-2879 – Fax

GREAT-WEST FINANCIAL

SUPPLEMENTAL ATTENDING PHYSICIAN'S STATEMENT FOR ORTHOPEDIC/NEUROLOGICAL

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) Current symptoms (Please ✓ those that apply):

☐ Cervical pain ☐ Thoracic pain ☐ Lumbosacral pain

☐ Paresthesia, peripheral neuropathy, sensory disturbances in radicular or dermatomal pattern in the..... ☐ arms ☐ legs ☐ trunk ☐ hands

☐ Subjective weakness ☐ Lack of coordination

☐ Stiffness or impaired range of motion

(b) Objective findings (including current X-ray Reports, Laboratory Data and any clinical findings) Current Weight________ Height ________

(c) Physical finding (Please ✓ those that apply):

☐ Loss or distortion of normal spinal curve

☐ Distinct muscle spasm

☐ Neurological abnormalities of arms, legs (i.e. reflex changes, atrophy, paralysis, contracture)

(d) 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 confined?... ☐ Yes ☐ No If "Yes" give name and address of hospital

____

____

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

6. 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:

7. Please briefly describe your patient's functional limitations.

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

9. 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:

____

10. Additional remarks or comments

______________________ ______________________ (   ) ______________________

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.*