GREAT-WEST FINANCIAL

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SUPPLEMENTAL ATTENDING PHYSICIAN'S STATEMENT FOR PSYCHOLOGY/PSYCHIATRY

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?..... 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..... ☐ Weekly ☐ Monthly ☐ Other (specify)

4. Nature of Treatment 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. 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:

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.***