Disability RMS
Expertise • Performance • Brand Protection

**Please return completed form to:**

**Disability Reinsurance Management Services, Inc.**
300 Southborough Drive, Suite 200
South Portland, ME 04106-6914
Phone: (877) 254-0085
Fax (207) 766-3448

**Please Return By:** _____

**ATTENDING PHYSICIAN'S STATEMENT**
**THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY**

Patient's Name: Date of Birth:

**1. DIAGNOSIS/CURRENT DISABLING CONDITION**

a. Current Diagnosis (including any complications):

b. Current Symptoms/Findings (include any office notes or test results):

c. Height: _____ Weight: _____

**2. DATES OF TREATMENT**

a. Date of Disability: _____

b. Date of last visit: _____ Date of next visit: _____

c. Frequency: ☐ Weekly ☐ Monthly ☐ Other/PRN _____

**3. NATURE OF TREATMENT**

a. Current treatment plan and medications prescribed:

b. If your patient has undergone any surgery since your last report, please list type of surgery and date(s) performed.

c. If your patient is receiving treatment from any other health care providers please provide name(s) and address(es).

d. Please include copies of any updated office notes or test results since last report.

**4. EXTENT OF DISABILITY** *****IMPORTANT*****

a. Please provide current restrictions (what your patient should not do):

b. Please provide current limitations (what your patient cannot do):

**5. CARDIAC** (if applicable)

a. Functional Capacity (American Heart Assn): ☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

b. Blood Pressure (last visit): _____/_____
Systolic Diastolic

**6. PHYSICAL IMPAIRMENT**

In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (please indicate appropriate number of hours):

| | |
|---|---|
| ___ Hrs. Sedentary Activity | 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours. |
| ___ Hrs. Light Activity | 20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours. |
| ___ Hrs. Medium Activity | 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing. |
| ___ Hrs. Heavy Activity | 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing. |

**7. MENTAL/NERVOUS IMPAIRMENT** (If applicable)

- ☐ Class 1 -- Patient able to function under stress and able to engage in interpersonal relations (No limitations).
- ☐ Class 2 -- Patient able to function in most stress situations and engage in limited interpersonal relations (Slight limitation).
- ☐ Class 3 -- Patient able to engage in only limited stress situations and engage in limited interpersonal relations (Moderate limitation).
- ☐ Class 4 -- Patient unable to engage in stress situations or engage in interpersonal relations (Marked limitation).
- ☐ Class 5 -- Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitation).

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

**8. PROGRESS**

a. Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Regressed?

b. Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

c. Do you expect any significant improvement in the future? ☐ Yes ☐ No

If yes, will patient recover sufficiently to perform the duties of his/her: ☐ Own Occupation ☐ Any Occupation

When? _____/_____/_____ ☐ 1 Month ☐ 1- 3 Months
Month Day Year ☐ 3- 6 Months ☐ Never

**9. REHABILITATION**

| | PATIENT'S JOB | | ANY OTHER WORK | |
|---|---|---|---|---|
| a. Is patient a suitable candidate for further rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc.) | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| b. Would vocational counseling and/or retraining be recommended? | ☐ Yes | ☐ No | ☐ Yes | ☐ No |

**10. REMARKS**

_____ _____
Name of Attending Physician (Print) Degree/Specialty

_____
Street Address

_____ _____ _____
City or Town State Zip Code

_____ _____ _____
Telephone Fax Tax ID #

_____ _____
Signature Date

Claim ID: **0901**