

Part 2 - ATTENDING PHYSICIAN'S STATEMENT – INITIAL ASSESSMENT

Authorization/Consent

I authorize any licensed physician, medical practitioner or health care professional who has observed me for diagnosis or treatment, any hospital, clinic, or other medical or medically related facility where I have been a patient, any public body, private health or social establishment, personal information agency, market intermediary, insurance company, institution, current or former employer, or person, to release to Coughlin & Associates Ltd. or its agents the documentation they require to administer this claim. I authorize Coughlin & Associates Ltd. to release such documentation to independent medical examiners, to my Plan Sponsor/Employer and to any other insurance company, organization, establishment or body when Coughlin & Associates Ltd. deems it necessary for the purpose of administering this claim. A photostat of this authorization is as valid as the original.

Patient Name _____ Patient Signature _____ Day _____ Month _____ Year _____

Note: The patient is responsible for obtaining this form and any charges for its completion, unless prohibited by law.

SECTION A: DIAGNOSIS

What is the primary diagnosis? _____

When did symptoms first appear or date accident occurred? _____
Day _____ Month _____ Year _____

What was the date of the patient's first visit for his/her condition? _____
Day _____ Month _____ Year _____

Please indicate all dates of visits for the current condition:

Mth.	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		

Planned frequency of visits: Weekly Monthly Other, specify: _____

Has the patient ever had the same or similar condition? Yes No If yes, please elaborate: _____

Is the patient's condition due to injury or sickness arising out of his/her employment? Yes No

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? Yes No

If yes, please elaborate: _____

Please list the patient's symptoms (including severity and frequency) identifying which of the symptoms listed you have objectively observed:

What are the patient's current limitations? Please be specific. _____

What are the patient's current restrictions? Please be specific. _____

Please indicate the date the patient stopped working based on your recommendation. _____
Day _____ Month _____ Year _____

To the best of my knowledge, the patient has been totally disabled,

From _____ To _____
Day _____ Month _____ Year _____

Please provide date when patient should be able to return to work. _____
Day _____ Month _____ Year _____

SECTION B: TREATMENT

Has the patient been hospitalized? Yes No

If yes, please provide the name of the hospital and the date(s) of confinement. _____

If surgery was performed, please provide a description and date(s). _____

Please detail the patient's past and present treatment as well as response to treatment. _____

Please list all medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date Prescribed (D/M/Y)

If you have referred the patient to a specialist, please provide the name of the specialist(s) and area of specialty. _____

Name (please print) _____ Address _____ Telephone No. _____

Date _____ Signature _____ Specialty _____