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Supplementary Medical Information
Physical Medicine and Rehabilitation

(To be completed by personal physician or independent referral consultant in physical medicine and rehabilitation)

Member's Name _____

Member ID _____

Job Title _____

From this evaluation, we need a detailed, objective assessment of the patient's ability to perform the specific physical tasks now required by his/her work, or if he/she cannot, a prognosis for when he/she will be able to, with what treatment regimen and/or job modification. (DX & Ops Codeable to ICD-9, CPT).

Major Diagnosis _____

Secondary Diagnosis (if any) _____

Operation or Procedures ❑ Undertaken or ❑ Proposed (Check One)

Date _____

Date _____

Date of onset of most recent disability from this condition _____

Date of any prior disabilities from same _____

What conservative therapy was instituted for this condition? _____

❑ Cold ❑ Bedboard or Firm Mattress ❑ Heat ❑ Traction

If X-rays or other medical imaging were taken, what were the findings? (Attach report, if available) _____

Are there any specific findings of neurological deficit (calf measurement, anesthesia, paresthesia, etc.)? _____

Please specify positive findings from your physical examination in terms of limitations of range of motion, walking, standing, etc. Specify locations of pain and tenderness, etc., or other relevant findings. _____

List the specific values from any other investigations undertaken, such as lab test, EMGs, EKGs, stress tests, etc. that may be relevant to return to work. (Attach reports if available).

_____

In my opinion, the patient is:

❑ Able Now

❑ Unable Now (prognosis for return to work date :) _____

❑ To Return To Work Either:
- ❑ A) At His/Her Usual Job Or
- ❑ B) To A Job With These Restrictions (Please Specify) _____

_____

Dates of Treatment _____

Physician's Name (type or print) _____

Social Security # _____

TIN# _____

Signature _____

Medical Specialty _____

Address _____

Phone Number _____

Date of This Examination _____