

**HEALTH CARE PROVIDER STATEMENT**

**Phone: 1-888-825-5247 | Web: mySedgwick.com/Chevron | Fax: 855-800-5116 | PO Box 14648, Lexington, KY 40512**

The purpose of this form is to assist us in making a determination of disability. In completing this form, include sufficient detail of history, physical and diagnostic findings, clinical course, and therapy to enable us to make this determination. Include medical evidence such as laboratory test results, x-rays, consulting physician therapy updates, office/chart notes, etc for the period of xx/xx/xxx to present. Return completed form by **<MedicalDueDate>**.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT** | | | | | | | |
| LAST NAME: | | FIRST NAME: | | | | | |
| HEIGHT WEIGHT | | DATE OF BIRTH | | | CLAIM #: | | |
| **DIAGNOSIS** | | | | | | | |
| DIAGNOSIS (including any complications) | | | | | | | |
| SUBJECTIVE SYMPTOMS | | | | | | | |
| OBJECTIVE FINDINGS | | | | | | | |
| **DATES OF TREATMENT** | | | | | | | |
| DATE OF FIRST VISIT FOR THIS ILLNESS/INJURY | | | DATE OF LAST VISIT | | | | |
| FREQUENCY OF CURRENT VISITS [ ] Weekly [ ] Monthly [ ] Other (specify) | | | | | | | |
| **NATURE AND FREQUENCY OF TREATMENT** | | | | | | | |
| SHOW DATES WHERE APPROPRIATE |  | |  |  | | |  |
|  |  | |  |  | | |  |
| **PROGRESS** | | | | | | | |
| CHECK ONE [ ] Recovered [ ] Improved [ ] Unchanged [ ] Retrogressed | | | | | | | |
| PRESENT STATUS [ ] Ambulatory [ ] House confined [ ] Bed confined [ ] Hospitalized | | | | | | | |
| IF HOSPITALIZED, NAME OF HOSPITAL | CONFINED FROM | | | | | THROUGH | |
| INDICATE HOW ACTIVITIES ARE RESTRICTED | | | | | | | |

**Patient Name: <Employee Name>**

**Claim Number: <File Number>**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EFFECT OF PHYSICAL OR MENTAL IMPAIRMENT ON DUTIES OF JOB** | | | | | | | | | | | | | |
| Please explain in sufficient detail the extent to which patients illness or injury affects the capacity to work | | | | | | | | | | | | | |
| What are the patients current functional abilities with respect to the following activities:  Continuously With Rests  Sitting 1 2 3 4 5 6 7 8 (hrs.) [ ] [ ]  Standing 1 2 3 4 5 6 7 8 (hrs.) [ ] [ ]  Walking 1 2 3 4 5 6 7 8 (hrs.) [ ] [ ]  Lifting [ ] 0-10 lbs. [ ] 10-25 lbs. [ ] 25-50 lbs. [ ] 50 + | | | | | | | | | | | | | |
| Never Occasionally (up to 30%) Frequently (greater than 50%) No Restriction  Bending [ ] [ ] [ ] [ ]  Stooping [ ] [ ] [ ] [ ]  Climbing [ ] [ ] [ ] [ ]  Squatting [ ] [ ] [ ] [ ]  Reach above shoulder [ ] [ ] [ ] [ ]  Driving [ ] [ ] [ ] [ ] | | | | | | | | | | | | | |
| Are there any cognitive deficits that impair functional capacity? | | | | | | | [ ] Yes | | | [ ] No | |  | |
| If yes, please describe | | | | | | | | | | | | | |
| Do you expect the patient’s condition to improve in the future? | | (Circle) | | | | Yes | | No | | | | | |
| If yes, please give approximate date: | | | | If no, has the patient achieved maximum medical improvement? | | | | | | | | | |
| **CARDIAC (if applicable)** | | | | | | | | | | | | | |
| Functional capacity (American Heart Association) | | | | | BLOOD PRESSURE | | | | | | | | |
| [ ] Class 1 (no limitation) | [ ] Class 2 (slight limitation) | | | | \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_ | | |
| [ ] Class 3 (marked limitation) | [ ] Class 4 (complete limitation) | | | | Systolic | | | | | | Diastolic | | |
| **REMARKS AND RECOMMENDATIONS** | | | | | | | | | | | | | |
| Additional studies, consultations, or vocational training | | | | | | | | | | | | | |
| Name of attending physician (please print) | | | Specialty | | | | | | Telephone | | | | |
| Street address | | | City | | | | | | State | | | | Zip code |
| Physician signature (rubber stamp is NOT acceptable) | | | | | | | | | Date | | | | | |
| Are you related to the employee? Yes or No If yes, please specify how you are related | | | | | | | | | | | | | | |

“The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information,’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, information about the manifestation of a disease or disorder in an individual’s family members, the fact that an individual or an individual’s family member sought or received genetic services (including genetic testing, counseling, or education), or participated in clinical research  which includes such services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”