Attending Physician's Statement

Your patient is applying for Disability Benefits.

To be completed by the Treating Physician (Incomplete forms will be returned)

Employer Name

Mail or Fax to: TRISTAR
2835 Temple Avenue, Signal Hill, CA 90755
Tel: 844/702-2352
Fax: 562/495-6687
ICSFax@tristargroup.net

Patient's Last Name:	First Name:	Middle Initial:	Social Security Number: -- --

Date of Birth:	Height:	Weight:	Blood Pressure:	Gender: ☐ Female ☐ Male

The Genetic Information Non-Discrimination 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, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Primary Diagnosis, including ICD-10 or DSM code:	Secondary Diagnosis, including ICD-10 or DSM Code:
If patient is pregnant, give LMP date:	**If patient is pregnant give EDC:**
First Date of Treatment:	Last Date of Treatment:
Is the patient still under your care for this condition? ☐ Yes ☐ No	How often do you see the patient?

Symptoms

Is the condition work related? ☐ Yes ☐ No If "Yes" please explain:	Have you submitted a workers' compensation form? ☐ Yes ☐ No

Has the patient undergone surgery? ☐ Yes ☐ No If "Yes" please give date, procedure and result:	Will surgery be performed in the future? ☐ Yes ☐ No If "Yes" please give date and procedure:

Medications taken at present:

Has the patient been referred for medical rehab or therapy to another physician? ☐ Yes ☐ No
If "Yes" please give details:

Was the patient hospitalized? ☐ Yes ☐ No If "Yes" please give dates: **From** **through**	Name and address of hospital:

Limitations on patient's activities to include occupations restrictions and limitations:

Prognosis for recovery:

Patient continuously disabled from doing regular work: **From** **Through**	**OR** Will the patient require intermittent or reduced schedule? ☐ **Yes** ☐ **No** **From:** **Through:**

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s) Duration: _____ hours or ___ day(s) per episode	Is the patient competent to handle his/her financial affairs? ☐ Yes ☐ No

If still disabled, when should patient be able to Return to Work?
(Specific date required)

I hereby certify that the above statements truly describe the patient's disability (if any) and the estimated duration thereof. If I am a Nurse Practitioner I certify that I performed a physical examination of the above patient and that I collaborated with a physician prior to certifying the period of disability stated above.

Print or Type Physician's/Nurse Practitioner's Name as shown on License:	State License #:
Address:	City, State, Zip:
Telephone:	Fax:
Signature: (NO STAMP)	Date: