

Attending Physician's Statement				Mail or Fax to:	
Your patient is applying for Disability Benefits.				Innovative Care Systems, Inc.	
To be completed by the Treating Physician (Incomplete forms will be returned)		Employer Name		Integrated Disability Claims	
				Department	
				PO Box 11433 , Torrance, CA 90501	
				800/965-1444	
				Fax: 310/943-0348	
Patient's Last Name		First Name		Middle Initial	
Date of Birth		Height		Blood Pressure	
		Weight		Gender	
				<input type="checkbox"/> Female <input type="checkbox"/> Male	
Primary Diagnosis, including ICD9 or DSM code					
Secondary Diagnosis, including ICD9 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			How often do you see the patient?		
Symptoms					
Objective Findings					
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please explain:				Have you submitted a workers' compensation form? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient undergone surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give date, procedure and result:			Will surgery be performed in the future? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give details:					
Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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					
Is the patient competent to handle his/her financial affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No			Patient continuously disabled from doing regular work From _____ Through _____		
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. I am a(n)					
Specialty/Degree:			Licensed to practice in the State of:		
Print or Type Physician's Name as shown on License			State License #		
Address			City, State, Zip		
Telephone			Fax		
Signature: (NO STAMP)				Date	