# Suppemental Attending Physician's Statement for Cardiology

**Note:** Great-West assumes no responsibility for any expense incurred in the completion of this statement. When completed, please mail or fax this statement directly to Great-West or return form to patient.

### Please Print

<table>
<thead>
<tr>
<th>Name of patient</th>
<th>Date of birth</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient’s address</th>
<th>Number</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**1105/1106/104GP**

Plan number

1. **History**
   - (a) When did symptoms first appear or accident happen? Mo. _____ Day _____ Year _____
   - (b) Date patient ceased work because of disability: Mo. _____ Day _____ Year _____
   - (c) Names and addresses of other treating physicians:

2. **Current Findings**
   - (a) Blood Pressure _____ Pulse _____ Current Weight _____ Height _____
   - (b) Date of last examination: Mo. _____ Day _____ Year _____
   - (c) Please indicate current symptoms by placing a ✓ next to the ones that apply:
     - Is there chest pain? Yes [ ] No [ ] If yes, [ ] With exertion? [ ] Relieved by medication? [ ]
     - Is there shortness of breath? [ ] Yes [ ] No [ ] If Yes, [ ] With exertion only? [ ] Orthopnea [ ] Syncope [ ]
     - Is there paroxysmal nocturnal dyspnea? [ ] Yes [ ] No [ ] If Yes, [ ] Precipitating factors [ ] Palpitations [ ] Generalized weakness and/or malaise and/or fatigue [ ]
   - (d) Please advise frequency of patient’s pain, duration, precipitating factors and how it is relieved
   - (e) Objective findings (including current X-ray Reports, EKGs, laboratory data and any clinical findings)
   - (f) Diagnosis (including any complications)

3. **Dates of Treatment**
   - (a) Date of first visit: Mo. _____ Day _____ Year _____
   - (b) Date of last visit: Mo. _____ Day _____ Year _____
   - (c) Frequency: [ ] Weekly [ ] Monthly [ ] Other (specify)

4. **Nature of Treatment** (including date and type of surgery and medications prescribed, if any)

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Form M4954 (Rev.06/12)
5. **Progress**
   (a) Has patient……………………………………. □ Recovered? □ Improved? □ Remained unchanged? □ Retrogressed?
   (b) Is patient…………………………………… □ Ambulatory? □ House confined? □ Bed confined? □ Hospital confined?
   (c) Has patient been hospital confined?…………………………………….. □ Yes □ No If “Yes” give name and address of hospital

   Date of Admission _____/_____/______ Date of Discharge _____/_____/______

6. **Cardiac**
   (a) Functional capacity………………………….. □ Class 1 (No limitation) □ Class 2 (Sight limitation)
       (American Heart Association) □ Class 3 (Marked limitation) □ Class 4 (Complete limitation)
   (b) **Blood pressure** (last visit)……………… Systolic _______ /Diastolic __________

7. **Physical Impairment (as defined in US Dept of Labor Dictionary of Occupations Titles) Please offer your recommendations**
   □ Class 1 - No limitation of functional capacity; capable of heavy work* .................................................................No restrictions (0-10%)
   □ Class 2 - Medium manual activity* ................................................................................................................... (15-30%)
   □ Class 3 - Slight limitation of functional capacity; capable of light work* ............................................................................. (35-55%)
   □ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity............................................ (60-70%)
   □ Class 5 - Severe limitation of functional capacity; incapable of minimal (Sedentary*) activity........................................................... (75-100%)
   □ Remarks:

8. Please provide us with a brief description of your patient’s physical limitations:

9. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? □ Yes □ No

10. **Current Condition**
    (a) Is patient now totally disabled from his/her own occupation? □ Yes □ No
    (b) Is patient now totally disabled from all occupations? □ Yes □ No
    (c) If not now totally disabled, when was patient able to resume his/her regular duties? □ Part-time _____/______/______ □ Full-time _____/______/______
        If part-time # of hours worked per week __________
    (d) What duties of patient’s job is he/she incapable of performing?

11. **Prognosis**
    Do you expect a fundamental or marked change in the future? □ Yes □ No
    (a) If yes, when will patient recover sufficiently to perform his/her regular duties? □ 1 mo. □ 1-3 mo. □ 3-6 mo. □ Never
    (b) If no, please explain:

12. **Remarks**

Name (Attending Physician) / Please Print __________________________ Degree / Specialty __________________________ Telephone (____)__________________
Street Address _______________________________________________________ Fax (____)__________________
Cty or Town State Zip Code ________________________________

Signature * __________________________ Date __________________________

*Stamped signature or signature other than physician’s own signature will not be accepted.