REPORT OF PHYSICIAN

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

Please complete this form in its entirety. In order for this form to be accepted, please submit the last 12 months of medical records. Failure to complete this form in its entirety could result in a delay in processing. All pages of this form are required to be returned to be considered a completed form. OPERS' third-party administrator may be contacting you regarding this member.

STEP 1: Member's Personal Information

This section is required to be completed or the form will be invalid.

Social Security Number ___ — ___ — ____

-OR-

OPERS ID

First Name | MI | Last Name

Date of Birth ___ / ___ / ____

Gender: ◯ Male ◯ Female ◯ Prefer Not To Say

Address

City | State | ZIP Code

Home Phone Number ___ — ___ — ____

Work Phone Number ___ — ___ — ____

Cell Phone Number ___ — ___ — ____

Preferred Telephone Number for Contact:

◯ Home ◯ Work ◯ Cell

Preferred Time to Call:

◯ Morning ◯ Afternoon ◯ Evening

E-mail Address

See next page

STEP 2: Attending Physician Information - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.* This section is required to be completed or the form will be invalid.

Physician Name MD DO

Specialty

Board Certified (ABMS): Yes No Sub-certification (if applicable): Yes No

Physician Office Mailing Address

City State ZIP Code

Physician Office Phone Number Fax Number

Physician E-mail Address

Primary Office Contact

Primary Office Contact Phone Number Fax Number

Primary Office Contact E-mail Address

Office Hours: _____ Preferred Time to Call: _____

Preferred Method of Contact: Phone Fax E-mail

See next page

STEP 3: Patient Information - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.*

Treated Member From: ___/___/___ To: ___/___/___

Frequency of Office Visits for Disabling Condition(s): ◯ Monthly ◯ Qtr. ◯ Semi-ann. ◯ Ann. ◯ Other

Date of Last Office Visit for the Disabling Condition(s): ___/___/___

Do you have knowledge that the claimant/patient is receiving Workers' Compensation benefits for this disabling condition(s)?

◯ Yes ◯ No ◯ I do not know

Are you the doctor of record for the Bureau of Workers' Compensation claim?

◯ Yes ◯ No ◯ N/A

STEP 4: Physician Determination - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.*

For a member to be permanently disabled from their last public employment position, the disabling condition must be expected to last for at least 12 months and prevent the member from performing the duties of their last public employment position. Disability coverage does not extend to illness or injuries resulting from elective cosmetic surgery other than reconstructive surgery. Please include any test results that enabled you to make your diagnosis(es).

You must complete either the YES section or the NO section below in its entirety for the form to be considered valid. If one of these sections is not completed this form will be invalid.

Do you consider this member to be permanently disabled from their last public employment position as described above? ◯ Yes ◯ No

If YES, complete below:

What is the member's Primary Disabling Condition?

Corresponding ICD Code:

Date on which illness or injury occurred: ___/___/___

Date on which illness or injury became permanently disabling: ___/___/___

Has the member's condition progressed since the illness or injury occurred? ◯ Yes ◯ No

See next page

If NO, complete below:

Date on which illness or injury occurred: / /

What is the expected date the member could return to their public employment position? / /

Could the member return to work with restrictions and/or limitations? Yes No

If yes, please describe:

Part 2: This section is required to be completed or the form will be invalid.

PROGNOSIS FOR RECOVERY FROM DISABLING CONDITION(S)

Physician's Name

Physician's Signature _____ Today's Date / /

Do not print or type name

Physician's Medical Title

MD DO

See next page

STEP 5: Physician Findings - *must be completed by the member's attending physician who is a licensed and practicing MD or DO. PLEASE ATTACH ALL MEDICAL AND/OR PSYCHOLOGICAL RECORDS WITHIN THE LAST 12 MONTHS, INCLUDING OFFICE NOTES, CLINIC AND ER VISITS, LABS, ALL TEST RESULTS AND DISCHARGE SUMMARIES. PLEASE NOTE – UNABLE TO ACCEPT DIGITAL MEDIA, ONLY INCLUDE REPORT FINDINGS.*

Please complete each applicable section based on the disabling condition. The medical data provided by you in the report (clinical findings, diagnosis, test results) will be used to adjudicate the disability determination process.

PART I – Medical Information

(For disabling psychological conditions only, proceed to Part II.)
(If no disabling psychological conditions, proceed to Part III upon completion.)

CURRENT MEDICATIONS

MEDICAL HISTORY *[Include hospitalizations within the past five years. (List facilities, dates and reasons for admission(s))]*

PHYSICAL EXAMINATION *Complete the following section **only** providing information that is related to the disabling condition(s).*					
Temperature:	Blood Pressure:	Height:	Weight:	Pulse:	Respiratory Rate:
General appearance:					

VISION *[For example: Ophthalmological changes, cataract(s); glaucoma; macular problems; diabetic retinopathy; Certificate of Blindness; best corrected visual acuity; visual field testing]*

HEARING *[For example: Whispered/spoken word; cochlear implant; Other amplification devices; Use of American Sign Language (ASL); Audiological Evaluation (including audiogram); vestibular testing; electronystagmography (ENG)]*

See next page

RESPIRATORY SYSTEM

[For example: Pulmonary function; lung function (wheezes, rhonchi, or rales); cyanosis/dyspnea; chest x-ray report; pulmonary function test; arterial/gas studies; in the case of pulmonary tuberculosis, provide sputum culture results]

CARDIOVASCULAR SYSTEM

[For example: Blood pressure readings; indication of chest pain; edema, pigmentation, cyanosis or ulceration; end-organ damage as result of hypertension; indicate New York Heart Classification; chest x-ray report; electrocardiogram (EKG) report; echocardiogram (ECHO) report; Exercise Tolerance Test]

DIGESTIVE SYSTEM

[For example: Weight loss; liver studies; x-ray report; endoscopy; colonoscopy; pathology]

GENITOURINARY SYSTEM

[For example: Report of dialysis treatment; history of transplant; BUN; Creatine Clearance]

HEMATOLOGICAL SYSTEM

[For example: Indication of the following: anemias, bone marrow disorders, etc.; blood transfusions; stem cell transplant; complete blood count]

See next page

SKIN

[For example: Extent of lesions and part of body system impacted; if burn(s), total body surface area involvement; other pertinent findings if critical areas of the body are involved (such as palms of hands and soles of feet); biopsy; pathology]

ENDOCRINE SYSTEM

[For example: Diabetes; evidence of neuropathy; acidosis; amputations; ophthalmological changes; lab studies]

MUSCULOSKELETAL SYSTEM

[For example: Limitation of motion and the degree; comment on history of pain, swelling, and stiffness; MRI report; x-ray report; ESR/RF studies]

NEUROLOGICAL SYSTEM

[For example: Reflexes; motor strength; sensation (light touch, pin prick, vibration and position); cranial nerves; cerebellar function (include observed ambulation); mental status (i.e., oriented X3, confused, etc.); electromyography (EMG); nerve conduction study (NCS); electroencephalogram (EEG)]

MALIGNANT NEOPLASMS

[For example: Type, extent and site of the primary recurrent or metastatic lesion; treatment plan and prognosis; operative procedures including biopsy or needle aspiration; operative note or pathology report]

See next page

IMMUNE SYSTEM *[For example: Indication of the following: autoimmune disorder(s) (such as Lupus), immunodeficiency disorder(s) (primary or acquired), HIV infection, etc.; any constitutional symptoms such as fatigue, fever, malaise, etc.; blood studies; angiography; x-ray; CAT scan report; MRI report]*
OTHER *[Please indicate any other pertinent physical examination findings and/or laboratory/diagnostic studies not listed above.]*

Part II – Psychological Information

(If no disabling psychological conditions, proceed to Part III.)

CURRENT MEDICATIONS
PSYCHIATRIC HISTORY *[Include hospitalizations within the past five years. (List facilities, dates and reasons for admission(s).)]*

See next page

MENTAL STATUS ASSESSMENT

*Complete the following section **only** providing information that is related to the disabling condition(s). (If no psychological conditions, proceed to Part III.)*

Current clinical signs and symptoms that support the diagnosis(es) (sleep, interest, guilt, energy, concentration, appetite, psychomotor, suicidal ideation, etc.)

APPEARANCE/ATTITUDE/BEHAVIOR

[For example: Personal hygiene and grooming]

ORIENTATION

[For example: Person, date, place]

MOOD AND AFFECT

[For example: Labile, blunt, flat]

SPEECH

[For example: Pressured, paucity of speech, etc.]

See next page

THOUGHT PROCESS

[For example: Dissociation, blocking, flight of ideas, etc.]

THOUGHT CONTENT

[For example: Phobias, obsessions, delusions, ideas of reference, etc.]

PERCEPTIONS

[For example: Hallucinations – auditory or visual]

COGNITION

[For example: Impairment of memory, judgment/ability to perform calculations, level of intellectual function, ability to concentrate and/or learn]

SOCIAL

[For example: Ability to interact with others or those in a position of authority]

OTHER

[Please indicate any other pertinent clinical findings not listed above and/or results of neuropsychiatric testing.]

See next page

Part III – Treatment and Prognosis

HISTORICAL TREATMENT *[For example: Successful and failed treatments]*
CURRENT TREATMENT

Has member shown medical improvement with Current Treatment? ◯ Yes ◯ No

If yes, indicate level of improvement: ◯ Fair ◯ Moderate ◯ Good ◯ Excellent