# DISABILITY CONTINUED MEDICAL TREATMENT FORM

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 along with the last 6 months of medical records. Failure to complete this form in its entirety could result in a delay in processing.

**OPERS Disability Standard**
For a member to be considered 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 the member's last public employment position.

## **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

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

Secondary Office Contact

Secondary Office Contact Phone Number

— —

Fax Number

— —

Secondary Office Contact E-mail Address



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

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 the member's last public employment position.

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

**If you selected NO, what is the expected date the member could return to their public employment position?** ___/___/_____

**If you selected NO, could the member return to work with restrictions and/or limitations?** ◯ Yes ◯ No

If **YES**, please describe:

***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 6 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.)

| PRIMARY DISABLING CONDITION |
| --- |
| |

| CURRENT MEDICATIONS |
| --- |
| |

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



*See next page*

## 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)]*

## 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]*



*See next page*

## 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).)]*

**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.)



*See next page*

**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.]*

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


*See next page*

**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*

**STEP 6:** Continued Medical Treatment - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.*

Please include any test results that enabled you to make your diagnosis(es).

## Part III – Treatment and Prognosis

| **HISTORICAL TREATMENT**<br>*[For example: Successful and failed treatments]* |
|---|
| |
| **CURRENT TREATMENT** |
| |

Has member complied with current treatment? ◯ Yes ◯ No

Has member shown medical improvement with current treatment? ◯ Yes ◯ No

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