Attending Physician's Statement - #1 recomplete with Alice Cooper

Section A **Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT**			
Plan Member/Employee Name (Last, First, Middle Initial): **Cooper, Alice**	Home Phone # (+ Area Code):	Cell Phone # (+ Area Code): 312 556-8173	
Address (Street, City, Province, Postal Code): 586 Oak Street, Chicago IL			
Employer's Name: Schools Out LLC	Group Plan Number: STD3456123	Employee ID Number: 337669	DOB (08/15/1990)
Date Last Worked (07/02/2024):	Date Returned to Work or Expected Return to Work Date, if known (08/20/2024):	Please provide your: Height: 5'10" Weight: 170	
I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, for the purpose of investigating and assessing my claim (s), administering coverage (s) that I may have with Disability Company LLC and administering the group benefits plan. This consent may be revoked by me at any time by sending a written instruction. **I understand that I am responsible for any fees related to the completion of this form.** **I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.**			
Plan Member/Employee Signature: *Alice Cooper*		Date of Consent (07/05/2024):	
Section B		Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR	
I am the: Attending Physician ☒ Consulting Specialist ☐ Other ☐ (please specify)			
Diagnosis			
Primary: General Anxiety Disorder			
Secondary:			
Is this condition related to: Occupational Illness/injury ☐ Auto Accident ☐ If so, date of event: (dd/mm/yyyy):			

Date of first visit to you pertaining to this condition (06/05/2024)	First date of work absence due to this condition: (07/03/2024):

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☒
If yes, date: (dd/mm/yyyy) By whom:

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☒
If yes, please indicate requestor: (other insurance company, Workers Compensation)

- Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity:

Can't sleep, irritable, panic attacks, always tired, restless with constant worry due to job and manager

- Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	**Mild**	**Moderate**	Severe
Appearance	☒	☐	☐	☐
Memory	☒	☐	☐	☐
Energy/Vigor	☒	☐	☐	☐
Behavior	☐	☒	☐	☐
Decision Making	☒	☐	☐	☐
Socialization	☒	☐	☐	☐
Concentration/Focus	☐	☒	☐	☐
Speech	☒	☐	☐	☐
Affect/Mood	☒	☐	☒	☐

Insight/Judgment	☐	☒	☐	☐
Self-Criticism	☒	☐	☐	☐

Observations or comments supporting the above:

Patient is often distracted and restless. Avoids eye contact.

- Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

Workplace Issues ☒	**Social/Family Issues ☐**	**Financial/Legal Problems ☐**
Physical Condition ☐	**Alcohol/Drug Abuse ☐**	**Medication Side Effects ☐**
Pain Perception ☐	**Coping Skills ☐**	**Personality/Motivation ☐**

Other ☒ Please describe: Patient reports high stress at work and a poor relationship with his manager. He also reports he is not taking the prescribed meds and he does not like taking medication.

Please describe the supports in place, or planned, to assist with these issues:

Referred to Dr. Albert Einstein, Psychiatrist for medication management and therapy.

Investigations

Please attach copies of all relevant: test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
consultation reports
Do not provide genetic test results:

Are tests/investigations/consultations pending? Yes ☐ No ☐ Date report expected: (dd/mm/yyyy)

: Does the patient have an appointment booked with an specialist(s) in the near future?
Yes ☐ No ☐

Name of Specialist	Specialty	Date of Appointment: (dd/mm/yyyy)
1. **Dr. Richard Petty, PhD** 2.	1. Psychiatrist 2.	1. Unknown 2.

Reason for requesting the consultation:

Has any license held by the patient been restricted or revoked as a result of this condition? **Yes ☐ No ☐ Don't know ☒**	
If yes, as of when? (dd/mm/yyyy)	Type of license:

Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response
Lexapro	**15 mgs once a week, 6/05/2024**	**Same**	

Hospitalization

Is/was the patient hospitalized? Yes ☒ No ☐ Is future hospitalization anticipated? Yes ☐ No ☒

Date admitted (04/16/2024)	Date discharged (04/19/2024)	Institution Name HCA
Partial hospitalization 4/24/2024	**4/30/2024**	Tulip Hill Recovery

Treatment Details – Psychological (e.g., cognitive behavioral, drug/alcohol, group, family, marital, Day Hospital program)

Type of Therapy	**Name of provider or facility**	**Date treatment began (dd/mm/yyyy)**	**Frequency of visits**	**Date of last visit (dd/mm/yyyy)**	Response

			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

Overall Response to Treatment

Please describe the response to treatment to date:
Complete ☐ Partial ☐ None ☐ Too soon to tell ☒

Is the patient following the recommended treatment program? Yes ☐ No ☒
Please explain:

Patient is not taking prescribed medication.

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: Possible medication changes after seeing Dr. Einstein

Prognosis and Recovery

What return-to-work goals have been discussed with the patient? Please explain:

The goal is to return to work by 8/20/2024

Please provide the patient's prognosis for improvement: Patient needs to be off of work while attending outpatient therapy, adjusting to medication and after being seen by psychiatrist

Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis:

Note to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.		
Attending Physician (please print): Dr. Taylor Swift MD	**Certified Specialty:** **Family Medicine**	Physician's Stamp:
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code): **312 777-2233**	Fax # (+ Area Code):	
Email Address		
Signature: *Taylor Swift, MD*	**Date Signed (07/02/2024):**	

Attending Physician's Statement - #2

Section A **Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT**		
Plan Member/Employee Name (Last, First, Middle Initial): **Lawrence, Jennifer**	Home Phone # (+ Area Code):	Cell Phone # (+ Area Code): 615 627-6677
Address (Street, City, Province, Postal Code): 1852 Red Street, Nashville, TN		

Employer's Name: Schools Out LLC	Group Plan Number: STD3456123	Employee ID Number: 337669	DOB (08/15/1990)

Date Last Worked (04/15/2024):	Date Returned to Work or Expected Return to Work Date, if known (06/29/2024):	Please provide your: Height: 5'8" Weight: 125

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, for the purpose of investigating and assessing my claim (s), administering coverage (s) that I may have with Disability Company LLC and administering the group benefits plan. This consent may be revoked by me at any time by sending a written instruction.
I understand that I am responsible for any fees related to the completion of this form.
I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Plan Member/Employee Signature: *Jennifer Lawrence*	Date of Consent (04/16/2024):

Section B	Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR

I am the: Attending Physician ☒ Consulting Specialist ☐ Other ☐ (please specify)

Diagnosis

Primary: General Anxiety Disorder

Secondary: Major Depressive Disorder

Is this condition related to:
Occupational Illness/injury ☐ Auto Accident ☐ If so, date of event: (dd/mm/yyyy):

Date of first visit to you pertaining to this condition (02/20/2024)	First date of work absence due to this condition: (04/16/2024):

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☒
If yes, date: (dd/mm/yyyy) By whom:

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☒
If yes, please indicate requestor: (other insurance company, Workers Compensation)

- Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity:

Can't sleep, irritable, panic attacks, always tired, restless with constant worry due to job and manager

- Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	**Mild**	**Moderate**	Severe
Appearance	☒	☐	☐	☐
Memory	☒	☐	☐	☐
Energy/Vigor	☐	☒	☐	☐
Behavior	☐	☒	☐	☐
Decision Making	☒	☐	☐	☐
Socialization	☒	☐	☐	☐
Concentration/Focus	☐	☒	☐	☐
Speech	☒	☐	☐	☐
Affect/Mood	☐	☐	☒	☐

Insight/Judgment	☐	☒	☐	☐
Self-Criticism	☒	☐	☐	☐

Observations or comments supporting the above:

Patient is often distracted and restless. Avoids eye contact

- Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

Workplace Issues ☒	**Social/Family Issues ☐**	**Financial/Legal Problems ☐**
Physical Condition ☐	**Alcohol/Drug Abuse ☐**	**Medication Side Effects ☐**
Pain Perception ☐	**Coping Skills ☐**	**Personality/Motivation ☐**

Other ☒ Please describe: Patient started having symptoms in February due to high stress at work and a poor relationship with her manager. She is also continuing to deal with the death of her mother 6 months ago

Please describe the supports in place, or planned, to assist with these issues:

Referred to Dr. Richard Petty, Psychiatrist for medication and therapy.

Investigations

Please attach copies of all relevant: test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
consultation reports
Do not provide genetic test results:

Are tests/investigations/consultations pending? Yes ☐ No ☐ Date report expected: (dd/mm/yyyy)

: Does the patient have an appointment booked with an specialist(s) in the near future?
Yes ☐ No ☐

Name of Specialist	Specialty	Date of Appointment: (dd/mm/yyyy)
1. **Dr. Richard Petty, PhD** 2.	1. Psychiatrist 2.	1. Unknown 2.

Reason for requesting the consultation:

Has any license held by the patient been restricted or revoked as a result of this condition? **Yes ☐ No ☐ Don't know ☒**	
If yes, as of when? (dd/mm/yyyy)	Type of license:

Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response
Lexapro	**10 mgs once a week, 4/16/2024**	**Same**	

Hospitalization

Is/was the patient hospitalized? Yes ☒ No ☐ Is future hospitalization anticipated? Yes ☐ No ☒

Date admitted (04/16/2024)	Date discharged (04/19/2024)	Institution Name HCA
Partial hospitalization 4/24/2024	**4/30/2024**	Tulip Hill Recovery

Treatment Details – Psychological (e.g., cognitive behavioral, drug/alcohol, group, family, marital, Day Hospital program)

Type of Therapy	**Name of provider or facility**	**Date treatment began (dd/mm/yyyy)**	**Frequency of visits**	**Date of last visit (dd/mm/yyyy)**	Response

Inpatient	**HCA**	**4/16/2024**	**Wkly ☐ Mthly ☐ Other ☒**	**4/19/2024**	Daily inpatient Therapy
Out patient	**Tulip Hill**	**4/24/2024**	**Wkly ☐ Mthly ☐ Other ☒**	**4/30/2024**	Daily – Mon - Fri
			Wkly ☐ Mthly ☒ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

Overall Response to Treatment

Please describe the response to treatment to date:
Complete ☐ Partial ☐ None ☐ Too soon to tell ☒

Is the patient following the recommended treatment program? Yes ☒ No ☐
Please explain:

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: Possible medication changes after seeing Dr. Petty

Prognosis and Recovery

What return-to-work goals have been discussed with the patient? Please explain:

The goal is to return to work by 7/1/2024

Please provide the patient's prognosis for improvement: Patient needs to be off of work while attending outpatient therapy, adjusting to medication and after being seen by psychiatrist

Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis:

Note to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.		
Attending Physician (please print): Dr. Jessica Biel MD	**Certified Specialty:** **Family Medicine**	Physician's Stamp:
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code): **615 555-6723**	Fax # (+ Area Code):	
Email Address		
Signature: Jessica Biel	**Date Signed (04/25/2024):**	

Attending Physician's Statement - #3

Section A **Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT**		
Plan Member/Employee Name (Last, First, Middle Initial): **Blunt, Emily**	Home Phone # (+ Area Code):	Cell Phone # (+ Area Code): 212 636-5798
Address (Street, City, Province, Postal Code): 4223 42nd Ave, New York, NY		

Employer's Name: Red Sparrow Inc.	Group Plan Number: STD3456123	Employee ID Number: 993452	DOB (08/15/1990)

Date Last Worked (04/12/2024):	Date Returned to Work or Expected Return to Work Date, if known (08/12/2024):	Please provide your: Height: 5'7" Weight: 125

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, for the purpose of investigating and assessing my claim (s), administering coverage (s) that I may have with Disability Company LLC and administering the group benefits plan. This consent may be revoked by me at any time by sending a written instruction.
I understand that I am responsible for any fees related to the completion of this form.
I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Plan Member/Employee Signature: *Emily Blunt*	Date of Consent (04/11/2024):

Section B	Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR

I am the: Attending Physician ☒ Consulting Specialist ☐ Other ☐ (please specify)

Diagnosis

Primary: General Anxiety Disorder

Secondary: Major Depressive Disorder

Is this condition related to:
Occupational Illness/injury ☐ Auto Accident ☐ If so, date of event: (dd/mm/yyyy):

Date of first visit to you pertaining to this condition (02/20/2024)	First date of work absence due to this condition: (04/16/2024):

Has the patient been treated for this same or similar condition in the past? Yes ☒ No ☐
If yes, date: (02/07/2023) By whom: Dr. Dave Grohl PhD

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☒
If yes, please indicate requestor: (other insurance company, Workers Compensation)

- Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity:

Panic attacks, can't sleep, won't leave the house, always tired, restless, withdrawn, unable to focus

- Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	**Mild**	**Moderate**	Severe
Appearance	☐	☒	☐	☐
Memory	☒	☐	☐	☐
Energy/Vigor	☐	☐	☒	☐
Behavior	☐	☐	☒	☐
Decision Making	☐	☐	☒	☐
Socialization	☐	☐	☐	☒
Concentration/Focus	☐	☐	☒	☐
Speech	☒	☐	☐	☐
Affect/Mood	☐	☐	☒	☐

Insight/Judgment	☐	☒	☐	☐
Self-Criticism	☐	☒	☐	☐

Observations or comments supporting the above:

Patient is often distracted and restless. Appears overwhelmed by simple questions. Appearance – dis-shelved. Avoids eye contact

- Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

Workplace Issues ☐	**Social/Family Issues ☐**	**Financial/Legal Problems ☐**
Physical Condition ☐	**Alcohol/Drug Abuse ☐**	**Medication Side Effects ☐**
Pain Perception ☐	**Coping Skills ☒**	**Personality/Motivation ☒**

Other ☒ Please describe: Patient describes having depression on and off since her teenage years but the last two the symptoms have worsened to the point she is afraid to leave her house. She is divorced and lives alone finding it hard to care for her daily needs. She has lost 15 lbs in the last 6 months and says she does not have the energy to make meals. She recently accepted taking medication as she would not take it in the past.

Please describe the supports in place, or planned, to assist with these issues:

Started in patient therapy and treatment at Manhattan Psychiatric Center on July 15, 2024

Investigations

Please attach copies of all relevant: test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
consultation reports
Do not provide genetic test results:

Are tests/investigations/consultations pending? Yes ☒ No ☐ Date report expected: (dd/mm/yyyy)

: Does the patient have an appointment booked with an specialist(s) in the near future?
Yes ☒ No ☐

Name of Specialist	Specialty	Date of Appointment: (dd/mm/yyyy)
1. **Dr. Dave Grohl, MD, PhD** 2.	1. Psychiatrist 2.	1. 08/01/2024

Reason for requesting the consultation:

Has any license held by the patient been restricted or revoked as a result of this condition? **Yes ☐ No ☒ Don't know ☐**

If yes, as of when? (dd/mm/yyyy)	Type of license:

Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response
Celexa	**20 mgs daily, 4/16/2024**	**Same**	
Savella	**40 mgs daily, 6/6/2024**	**Same**	

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☒ Is future hospitalization anticipated? Yes ☒ No ☐

Date admitted (07/15/2024)	Date discharged 08/02/2024)	Manhattan Psychiatric Center
Out-patient program (08/05/2024)	**Est, 8/30/2024**	Manhattan Psychiatric Center

Treatment Details – Psychological (e.g., cognitive behavioral, drug/alcohol, group, family, marital, Day Hospital program)

Type of Therapy	**Name of provider or facility**	**Date treatment began (dd/mm/yyyy)**	**Frequency of visits**	**Date of last visit (dd/mm/yyyy)**	Response

Inpatient	**Manhattan Psychiatric Center**	**7/15/2024**	**Wkly ☐ Mthly ☐ Other ☒**	**Onging**	Daily inpatient Therapy
Out patient	**Manhattan Psychiatric Center**	**8/05/2024**	**Wkly ☒ Mthly ☐ Other ☒**	**Until 8/30/24**	3 days a week
			Wkly ☐ Mthly ☒ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

Overall Response to Treatment

Please describe the response to treatment to date:
Complete ☐ Partial ☒ None ☐ Too soon to tell ☐

Is the patient following the recommended treatment program? Yes ☒ No ☐
Please explain:

Are there any plans to change or augment the current treatment program? Yes ☐ No ☒

If so, please explain: Possible medication changes after inpatient treatment

Prognosis and Recovery

What return-to-work goals have been discussed with the patient? Please explain:

The goal is to return to work by 9/2/2024

Please provide the patient's prognosis for improvement: Patient needs to be off of work while attending inpatient and then outpatient therapy. She will be re-evaluated at the end of outpatient therapy

Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis:

Note to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.		
Attending Physician (please print): Dr. David Grohl, MD, PhD	**Certified Specialty:** **Psychiatry**	Physician's Stamp:
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code): **212 454-6349**	Fax # (+ Area Code):	
Email Address		
Signature: *David Grohl, M.D., Ph.D*	**Date Signed (08/05/2024):**	