Health Care Provider Statement (HCPS)

To be completed by a treating health care provider.

WORK CONNECTIONS
UNIVERSITY OF MICHIGAN
Illness and Injury Assistance

A. PATIENT INFORMATION

1. Name of Patient		Date of Birth	SSN
2. Date of First Visit	Date of Last Visit	Date of Next Visit	

B. MEDICAL HISTORY

3. Primary Diagnosis	ICD 10	GAF
4. Secondary Diagnosis	ICD 10	GAF
5. Subjective Symptoms	When did symptoms first appear?	
6. Objective Findings (including diagnostic tests, laboratory or clinical findings)		
7. Treatment plan, medications, and duration of treatment		
8. If referring to another physician, please provide name and specialty		

C. HOSPITALIZATIONS and SURGICAL PROCEDURES

9. Name of Hospital	Date of Admission	Date of Discharge
10. Reason for Hospitalization		
11. Surgical Procedure, if applicable	Date Performed/Scheduled	CPT Procedure Code

D. PROGNOSIS and RETURN TO WORK

12. What is the medical prognosis? Excellent ☐ Good ☐ Fair ☐ Poor ☐ Guarded ☐

13. Has patient reached Maximum Medical Improvement (MMI)? Yes ☐ No ☐ — If no, estimated MMI date?

14. Has disability lasted, or is it expected to last, for a continuous period of not less than 12 months? Yes ☐ No ☐ — Is disability expected to result in death? Yes ☐ No ☐

15. On what objective evidence do you base your response to question 14?

16. What type of activities can patient do over the course of a day? Please describe with regard to functional capability for activities of daily living (ADL), such as cooking, household chores, shopping, etc., as defined by the Social Security Administration.

17. Can periodic exacerbations of this condition be expected? Yes ☐ No ☐
Is it medically necessary for the patient to be absent from work during these exacerbations? Yes ☐ No ☐

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

19. Please check one:
- ☐ Patient is capable of returning to work with **no restrictions** effective _____.
- ☐ Estimated return to work with **no restrictions** effective _____.
- ☐ Estimated return to work **with restrictions**. **Please indicate limitations on the attached Functional Abilities Form (FAF).**
- ☐ Patient is **unable to return to work** at this time. **Please indicate limitation on the attached Functional Abilities Form (FAF).**

E. PHYSICIAN'S INFORMATION

Physician's Name (please print):	Physician's Signature:	Date:
		Email:
Degree/Specialty:	Address:	Phone:
		Fax:

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