

PART A

TO BE COMPLETED BY PATIENT (MEMBER)

PATIENT'S NAME AND ADDRESS

DATE OF BIRTH

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

SIGNED (PATIENT OR PARENT IF MINDR)

PART B

ATTENDING PHYSICIAN'S STATEMENT

I. DIAGNOSIS:

METHOD OF DELIVERY:

II. HISTORY:

LMP ____/____/____ Para ____
EDD ____/____/____ Gravida ____
Previous Abnormal Pregnancy, Pregnancy Terminations or Surgical Deliveries: (specify, giving date and reason)

B/P ____ Date ____/____/____
Ht. ____ Wt. ____ Nor. ____
Date Last Weighed ____
During Pregnancy ____/____/____
Total Gain ____

III. DATE PATIENT DISABLED:

Mo. Day 20..... If delivered, what was the date: Mo. Day 20.....

IV. HOSPITALIZATION:

(a) Hospital _____ City _____ State—Zip _____ from ____/____/____ to ____/____/____
(b) Surgery performed _____ Date ____/____/____ Description _____

V. EXTENT OF DISABILITY: — Please review patient's job description on reverse side

- a) Is patient now totally disabled for his own occupation? Yes No b) Date patient did or will resume work?
Is patient now totally disabled for any other occupation? Yes No Regular Occupation Mo. _____ Day _____ 20 ____
Other Occupation Mo. _____ Day _____ 20 ____
- c) If patient was advised to cease work more than 4 weeks pre-delivery or will not be released to resume work at 6 weeks post-delivery, please complete below:

- 1) Subjective Complaints:
- 2) Objective Findings:
- 3) Laboratory Testing:
Date Test Result
- 4) Treatment:
- 5) In view of patient's job description, what specific duties of her job is she unable to perform, i.e., lifting, environmental factors.
- 6) Other Activity Limitations
- 7) Complications, if any

OTHER MAJOR HEALTH PROBLEMS AFFECTING PREGNANCY:

Toxemia	Prev. Preg. <input type="checkbox"/>	Curr. Preg. <input type="checkbox"/>	G.I. Disorders	Prev. Preg. <input type="checkbox"/>	Curr. Preg. <input type="checkbox"/>	Cardiovascular Disease	<input type="checkbox"/>	Alcohol Addiction	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Genital Tract Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Renal Disease	<input type="checkbox"/>	Drug Abuse/Addiction	<input type="checkbox"/>
Albuminuria	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis	<input type="checkbox"/>	Crippling Deformity	<input type="checkbox"/>
Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Other (Specify)	<input type="checkbox"/>
Rh & Blood Type Incompatibilities	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>		

Describe Conditions Indicated or Other Complications if not Listed:

VI. If patient will return to work with restriction or limitation, please describe and state how long it will be imposed.

REMARKS:

INDIVIDUAL PRACTITIONERS S.S. # _____
ALL OTHERS EMPLOYER I.D. # _____

MUST BE FURNISHED UNDER AUTHORITY OF LAW

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE TELEPHONE

STREET ADDRESS CITY OR TOWN STATE ZIP CODE