# PHYSICIAN'S REPORT

**VIRGINIA RETIREMENT SYSTEM**
**P.O. Box 2500 ◆ Richmond, VA 23218-2500**
**Toll-free 1-888-827-3847**
**Fax 804-786-9718**
***www.varetire.org***

Clear Form

| 1. Social Security Number |
|---|
| 2. Name |

The physician or other medical professional completes this form to describe the patient's illness(es) or condition(s) that may qualify the applicant for disability retirement. This information is used to make a decision about the applicant's disability retirement application.

**Note:** Review Part D to ensure all information supporting the diagnosis and treatment are submitted with this report.

## PART A. DESCRIPTION OF DISABLING ILLNESS

**3. List the physical functional limitations preventing the applicant from performing his or her usual work duties:**

## PART B. DIAGNOSIS AND TREATMENT

**4. Indicate the diagnosis(es) and the onset date (for each), and whether each is causing or contributing to the disability:**

| Diagnosis (Full diagnostic description) | Date of Onset | Causing or Contributing? |
|---|---|---|
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**5. Date the patient became unable to work:**

**6. Date of patient's most recent visit (which must have been within the last 6 months):**

**7. Date of patient's first visit pertaining to this disability:**

**8. List the initial objective findings:**

| 9. SSN |
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**10. List all current medications:**

| Medication | Dosage | Duration | Patient Compliance? |
|---|---|---|---|
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**11. Description of any other treatment including therapy, patient compliance and response:**

**12. What improvement can be expected within one year of treatment?**

**13. Report any hospitalizations including special tests and or examinations for heart, vision and radiology:**

**14. Describe any surgical procedures performed on the patient including name, description of procedure, and response:**

**15. How has the patient's condition improved, remained unchanged, or worsened over the past year?**

**16. Do you consider the patient's disabling condition(s) likely to be permanent?**

❑ Yes ❑ No

| 17. SSN |
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## PART C. MEDICAL PROFESSIONAL INFORMATION

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| **18. Name of Practice** |
| **19. Medical Professional's Name** (First, Middle Initial, Last) |
| **20. Mailing Address** (Street, City, State and ZIP+4) |
| **21. Telephone Number** |
| **22. Medical Professional Signature**<br>**NOTE:** Unless otherwise specified, the Virginia Retirement System will *not* assume any responsibility for payment of fees for furnishing the requested information.<br><br>Signature _____ Date _____ |

## PART D. DOCUMENTATION REQUIRED TO SUBSTANTIATE CLAIMS

If the disability application is based on any of the conditions listed in this section, the following documentation is *required* where pertinent to the disability. Place a check by the type of condition and by all attachments being submitted.

If the disability application is *not* based on any of the conditions listed in this section, the physician's responsibility remains to provide any documentation such as consultations, radiology reports, other reports, special tests, laboratory or diagnostic studies and support the diagnosis.

❑ **Musculo-Skeletal**

- ❑ Report on any surgical treatment, including name of procedure and/or copy of operative note
- ❑ Current comprehensive Orthopedic examination
- ❑ Report on rheumatoid factor and sedimentation rate
- ❑ Report on uric acid relative to gouty arthritis
- ❑ Physical finding for all joints involved, including any deformities, tissue and bone destruction, range of motion and limitation of motion
- ❑ Current reports of radiology reports of involved joints

❑ **Cardiac**

- ❑ EKG and echocardiograms
- ❑ Reports on exercise tolerance and stress
- ❑ Answers to the following questions: Is the patient able to climb one flight of steps or walk 200 yards on level ground? Do such activities bring on severe dyspnea and/or angina? Or what duration of physical activity can the patient tolerate?
- ❑ Location of edema
- ❑ Report of any other physical findings

❑ **Cancer**

- ❑ Report on the stage of cancer
- ❑ Treatment Plan
- ❑ Oncology report
- ❑ CT scans
- ❑ Bone scans
- ❑ Lab Results

| 23. SSN |
|---|
| |

❑ **Respiratory**

- ❑ Frequency, duration and severity of acute attacks of asthma, bronchitis, etc.
- ❑ Answer to the following question: Is the patient able to climb a flight of stairs or walk 100 yards without dyspnea?
- ❑ Frequency of emergency room visits or hospitalization each year
- ❑ Report of current pulmonary function studies, predicted and actual values with the results expressed in the CCs or liters and also in percent. Include the oxygen and carbon dioxide level of room air.

❑ **Neurological**

- ❑ Current comprehensive neurological examination dated within the last six months
- ❑ If the condition is a seizure disorder, give the frequency and severity of the seizures in the past year
- ❑ Report on current EEGs, CT scans, MRIs with dates
- ❑ Report on any of the following conditions which are present, indicating severity, distribution, and residual function in affected parts: Atrophy, paralysis, hemiplegia, impaired speech, tremors, gait, reflexes, and mental disturbances (including a report on cognitive ability)

❑ **Psychiatric**

- ❑ Psychiatric signs and symptoms
- ❑ Report of current psychiatric consultation to include disabling symptoms, diagnosis, treatment, and prognosis
- ❑ Number of appointments with psychiatrist, psychologist or medical social worker in the past two-year period and date of last appointment

❑ **Diabetes**

- ❑ Symptoms and complications
- ❑ History including onset date, length of treatment, and weight loss
- ❑ Current treatment, including insulin and medications
- ❑ Report on current blood sugars with date and/or A1C
- ❑ Report on current urinalysis with date

❑ **Visual**

- ❑ Report on visual acuity after best correction: R 20/_____ and L 20/_____
- ❑ Report of visual fields, including chart, if indicated
- ❑ Report on fundascopic findings
- ❑ Description of ocular tension
- ❑ Description of therapy and prognosis
- ❑ Information about whether or not the patient drives an automobile

❑ **Auditory-Vestibular**

- ❑ MRI or CT reports
- ❑ Audiogram with respect to puretone, SRT, and speech discrimination
- ❑ If patient has hearing aids, indicate the aided thresholds with respect to SRT and speech discrimination
- ❑ If vertigo or Menieres disease:
  - Frequency, duration and severity of attacks
  - ENG report
  - Report on vestibular function and gait
  - Report of any medical and surgical treatment

❑ **Digestive**

- ❑ Report on symptoms and treatment
- ❑ Endoscopies, radiological reports, and special studies
- ❑ Complete report of current lower or upper GI series with date, if pertinent

❑ **Fibromyalgia**

- ❑ Report of any tender points
- ❑ A functional capacity evaluation for the patient's job
- ❑ Psychiatric report, if applicable

❑ **Other** (Describe all documentation enclosed such as test results, consultation notes.)