INDIANA LABORERS PENSION FUND

PHYSICIAN'S REPORT

To the Board of Trustees,

Regarding: Name _____ Soc. Sec. No. _____

PLEASE MAKE YOUR REPORT COMPLETE ENOUGH TO ENABLE A REVIEWING PHYSICIAN TO DETERMINE THE NATURE AND SEVERITY OF IMPAIRMENT.

1. I examined this applicant on _____ at _____
month day year

PHYSICAL MEASUREMENTS Give applicant's height and weight at last visit.	inches _____ lbs. _____
HISTORY (a) When did present illness or injury occur? . . . . . . (b) Date applicant became unable to work? . . . . . . (c) Is there a previous history of this illness? . . . . . . If "yes," desribe	
PRESENT CONDITION (ALL MAJOR IMPAIRMENTS) (a) Subjective symptoms . . . . . . (b) Objective findings . . . . . . Give report of X-rays, ECG's, laboratory or diagnostic tests, with dates. Use separate sheet if neccesary. (c) Is applicant . . . . . Ambulatory? ☐ Bed confined? ☐ House confined? ☐ Hospital confined? ☐	
DIAGNOSIS	
DIAGNOSIS (a) Is condition static? . . . . . . (b) If not, what optimum improvement can be expected, if any? . . . . . . (c) When? 6 Months ☐ 1 Year ☐ Indefinite ☐ (d) Desribe specific restrictions, if any, on Patient's activity	

GCIU 10-09-M

(OVER)

If disability is due to CARDIAC, RESPIRATORY, ARTHRITIC, NEUROLOGICAL CONDITIONS please amplify below with latest findings and dates.

CARDIAC

(a) Precise diagnosis including functional and therapeutic classification, American Heart Ass'n . . . . . .

(b) Describe heart size and contour. . . . . .

(c) Blood pressure . . . . . .

(d) What kind and amount of activity or stress
Results in (1) Dyspnea
(2) Angina

(e) Edema - (Give location).

RESPIRATORY

(a) Acute attacks . . . . . .
Frequency, duration and severity . . . . . .
(b) Deformity of chest wall . . . . . .
(c) Emphysema . . . . . .
(d) Vital capacity in cc's . . . . . .
(e) What kind and amount of activity results in dyspnea . . . . . .
(f) If TB, give National TB Association Clasification . . . . .

ARTHRITIS

(a) Physical Findings -- Give specific findings for all joints involved; describe deformities, tissue and bone destruction, range of motion. . . . . .

(b) X-ray report . . . . . .

NEUROLOGICAL

Describe any of the following conditions that are present, indicating severity, distribution, and residual function in affected parts. . . . . .

Atrophy	Tremors
Paralysis	Gait
Hemiplegia	Reflexes
Impaired speech	Mental disturbances

Lab findings: Cerebrospinal fluid (Wassermann, protein, cell count, etc.) X-ray findings, EEG's, other . . . . . .

(Additional Narrative Report is Desirable)

Based on my examination and conversation with the applicant, it is my opinion that the disability:
(Circle words in brackets that apply)

a. (Was) (Was not) contracted, suffered, or incurred while the employee was engaged in, or the result of having engaged in a criminal enterprise, or

b. (Did) (Did not) result from addiction to narcotics, or

c. (Was) (Was not) self-inflicted, or

d. (Did) (Did not) result from service in the Armed Forces of the United States of America.

I hereby certify that: (Please initial only the box that best describes the applicant)

☐ I am of the opinion this applicant is totally and permanently disabled. The disability is expected to be permanent and continuous for the rest of the applicant's life.

☐ I am of the opinion this applicant can engage in employment for profit or pay, but not in the construction industry.

☐ I am of the opinion this applicant can engage in employment for profit or pay which is considered inconsistent with the definitions of Total & Permanent and/or Occupational Disability.

By: _____ Date: _____
Physician's Signature

_____ Address: _____
Printed Physician's Name

_____

01/10