LAW OFFICES OF
TAD J. BISTOR, LLC

POST OFFICE BOX 1454
HARTFORD, CONNECTICUT 06144-1454
TELEPHONE (860) 570-1435
FACSIMILE (860) 570-1292
EMAIL TAD@BISTORLAW.COM
ALT. EMAIL BISTORLAW@GMAIL.COM

ALSO ADMITTED IN NEW YORK

MEDICAL PROVIDER QUESTIONNAIRE

To be completed by the Patient's treating physician or other licensed medical provider. If completed by a medical provider other than a physician, if possible, please have the supervising physician review the information provided and sign where indicated at the bottom of the form. If additional space is needed to complete any question, please attach additional pages as necessary to complete your responses.

Patient's primary diagnosis:_____

Any secondary diagnoses:_____

_____

_____

Initial Date Seen:_____ Last Date Seen:_____ Next Appointment:_____

Treatment Plan:_____

_____

_____

_____

Medications with dosage information:_____

_____

_____

_____

Is the Patient medically unable to perform **any** work at this time? Yes _____ No _____

Has this Patient been advised to cease **full time work**? Yes _____ No _____

If Yes, symptoms preventing work:_____

_____

_____

_____

Estimated return to **full time work** date:_____

Is Patient able to work with restrictions? Yes _____ No _____ Part Time? Yes _____ No _____

If Patient is able to return to work with restrictions and/or part time, list the restrictions, work hours, capabilities, return to work date, and duration of these restrictions:

_____

_____

_____

_____

_____

_____

_____

If there is any other relevant information that has not been provided above, please provide it below.

_____

_____

_____

_____

_____

_____

_____

I certify that the above information is true and correct.

_____ _____

Medical Provider's Signature Date

_____ _____

Medical Provider's Name and Title (Please Print) Direct Telephone Number

_____

Supervisory Physician's Signature (If applicable)