aetna®

Capabilities and Limitations Worksheet

To be completed by the Attending Physician
Complete and sign the form using BLUE or BLACK ink.

Aetna International
Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.

Mail this completed form to:
Aetna International
Attn: Disability Claims Processing
P.O. Box 14560
Lexington, KY 40512-4560
USA

Phone: **866-326-1380** Toll Free Within U.S.A.
800-231-7729 Toll Free – Outside U.S.A. (via AT&T Direct Access Code)
813-775-0190 Direct or Collect outside U.S.A.

Fax: **855-806-0522** Within U.S.A. and via AT&T Direct Access Code from any country

Employee Name *(Last Name/Surname, First, Middle Initial)*	U.S. Social Security Number or EE ID#	Date of Birth (MM/DD/YYYY)

Gender ☐ Male ☐ Female	Job Title	Control Number

Current Diagnosis

Medications:

Indicate the percent of the day the following activities can be performed:
(**O**ccasional 1-33% or .5-2.5 hrs., **F**requent 34-66% or 2.6-5.0 hrs., **C**ontinuous 67-100% or 5.1-8 hrs., or **N**ever)

	O	F	C	N
Climbing	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Pulling	☐	☐	☐	☐
Pushing	☐	☐	☐	☐
Reaching above shoulder	☐	☐	☐	☐
Forward reaching	☐	☐	☐	☐
Carrying	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Twisting	☐	☐	☐	☐

	O	F	C	N
Hand Grasping ___R___L	☐	☐	☐	☐
Firm Hand Grasping ___R___L	☐	☐	☐	☐
Fine Manipulation ___R___L	☐	☐	☐	☐
Gross Manipulation ___R___L	☐	☐	☐	☐
Repetitive Motion ___R___L	☐	☐	☐	☐
Sitting ___R___L	☐	☐	☐	☐
Standing ___R___L	☐	☐	☐	☐
Stooping ___R___L	☐	☐	☐	☐
Walking ___R___L	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

Maximum weight patient is capable of lifting:

	O	F	C	N
1 - 5 lbs.	☐	☐	☐	☐
6 - 10 lbs.	☐	☐	☐	☐
11 - 20 lbs.	☐	☐	☐	☐
21 - 35 lbs.	☐	☐	☐	☐
36 - 50 lbs.	☐	☐	☐	☐
51 - 75 lbs.	☐	☐	☐	☐
75 - 100 lbs.	☐	☐	☐	☐
100 lbs. +	☐	☐	☐	☐

Approved Head and Neck Movements:

	Yes	No
Static Position	☐	☐
Frequent Flexing	☐	☐
Frequent Rotation	☐	☐

Can the Patient operate:

	Yes	No
A Motor Vehicle	☐	☐
Hazardous Machine	☐	☐
Power Tools	☐	☐

Limitations to:
Speaking _____hrs.
Vision (explain) _____
Depth Perception _____
Hearing (explain) _____

Exposure Limitations:

	Yes	No		Yes	No
Heat	☐	☐	Dust	☐	☐
Cold	☐	☐	Fumes	☐	☐
Dampness	☐	☐	Chemicals	☐	☐
Noise	☐	☐	Radiation	☐	☐

Total # of hours patient capable of working per day: 12 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐
Duration of restrictions: _____ Care Complete: Yes ☐ No ☐ Next Appointment: _____
Additional Comments:

_____
Physician's Signature

_____
Date *(MM/DD/YYYY)*

Are you a western trained physician? ☐ Yes ☐ No
University/Institution (include country) _____