_____Department of Social Services

MEDICAL REPORT FORM 402B

District: _____

Worker: _____

Phone#: _____

Date: _____

Client ID: _____

The Information provided on this form may be used to determine eligibility for federal and state programs using Social Security disability criteria.

A. Patient Information

Name of Patient: _____ Address: _____

Phone: _____ Date of Birth: _____

Physician's Name: _____

(Please Print or Type)

Address: _____ Phone _____

_____

Specialty: _____

Dates of Examination ____/____/____ First Visit: ____/____/____ Last Visit: ____/____/____

Presenting Symptoms: _____

_____

_____

Height: _____ Weight: _____ BP: _____ Muscle Strength (1/5 to 5/5): UE _____ LE _____

B. Diagnosis: (You must attach progress notes or any other general records currently available)

_____ ICD-9-CM _____ Onset Date _____

_____ ICD-9-CM _____ Onset Date _____

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_____ ICD-9-CM _____ Onset Date _____

HIV/AIDS INFECTION: Opportunistic and Indicator Diseases (Please check all those that apply).

☐ Bacterial Infections ☐ HIV Wasting ☐ Viral Infections ☐ Diarrhea ☐ Protozoan or Helminthic Infections

☐ Neurological Abormalities ☐ Fungal Infections ☐ Other, specify _____

CD4 count _____ Viral Load _____

Diagnostic Tests Performed: (You must attach results or provide the date when results will be available for any Laboratory test results or other diagnostic evaluations, including psychiatric and psychological evaluations.)

_____

_____

_____

_____

Treatment and Response: Include past treatment and response, if known, and current treatment and response. Please include therapy and recommendations:

_____

_____

_____

_____

MEDICATIONS: Include all prescription and nonprescription medications currently being taken, and side effects which may have implications for working, eg. drowsiness and dizziness, etc.

Name of Medication	Reason For Medication	Side Effects

C. **Referral(s) to Specialist Recommended: (**Please explain reasons for referral(s)

_____

_____

_____

D. **Physical Limitations**

In terms of the patient's ability to perform during an 8-hour workday with normal breaks, the patient can:

Activity	Unknown	No Restrictions	Never	1 hr	2 hrs	3 hrs	4 hrs	5 hrs	6 hrs	7 hrs	8 hrs
Sit											
Stand											
Walk											
Lift											
Climb											
Carry											
Bend											
Squat											
Climb											
Reach											
Crawl											

Check the **HEAVIEST** weight the patient can lift/carry.

☐ less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 25 lbs ☐ 50 lbs ☐ 100 lbs ☐ more than 100 lbs

Check the weight the patient can lift/carry **FREQUENTLY**.

☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ more than 50 lbs

The patient can be exposed to:

Environmental Conditions	Unknown	Never	Occasionally	Frequently
Extreme Cold				
Extreme Heat				
Humidity				
Chemicals				
Dust				
Fumes/Odors				
Noise				
Height				

Describe how these environmental factors limit the patient's activities: _____

_____

_____

The patient can use hands for repetitive action such as:

Hand Action	Yes	No	Unknown
Simple Grasping			
Pushing and Pulling of Arm Controls			
Fine Manipulation			

Visual Limitations: Visual Field: OD _____ OS _____ VA: _____ (After Corrections): _____

Hearing Limitations Yes ☐ No ☐ Minimal ☐ Moderate ☐ Extreme ☐

Speaking Limitations Yes ☐ No ☐ Minimal ☐ Moderate ☐ Extreme ☐

Is substance abuse present? Yes ☐ No ☐

Would the patient's current condition exist in the absence of current substance abuse? Yes ☐ No ☐ Unknown ☐

E. Mental Status Information:

Does the patient suffer from mental illness? Yes ☐ No ☐ If you answered "no" to the above, go directly to Section F

Please provide all five axes of a DSM-IV diagnosis:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V GAF score: current _____ highest level in the past year _____

Cognitive testing (list tests performed with results) VIQ _____ PIQ _____ FSIQ _____

Please check the appropriate degree of limitation for the following:

Degree of Limitation is defined as "Mild", "Moderate", "Marked" and "Extreme".
Moderate refers to an impairment or combination of impairments that produce symptoms that have an impact on ones ability to function independently, appropriately and effectively on a sustained basis.
Marked refers to an impairment or combination of impairments that produce symptoms that seriously interferes with ones ability to function independently, appropriately and effectively and on a sustained basis.
Extreme is defined as continuous and severe.

FUNCTIONAL LIMITATIONS	DEGREE OF LIMITATIONS				
	None	Mild	Moderate	Marked	Extreme
Restriction of Activities Of Daily Living	☐	☐	☐	☐	☐
Difficulties in Maintaining Social Functioning	None ☐	Mild ☐	Moderate ☐	Marked ☐	Extreme ☐
Difficulties in Maintaining concentration, Persistence or Pace	None ☐	Seldom ☐	Often ☐	Frequent ☐	Constant ☐
Repeated episodes of Decompensation, each of Extended duration	None ☐	Once or Twice ☐	Repeated (three or more) ☐	Continual ☐	

F. Based upon your evaluation has your patient's medical condition lasted or can it be expected to last at least 12 months?
Yes ☐ No ☐

If no, please give the expected length of time the patient will be unable to work.
____/_____/_____/To ____/_____/_____/
day month year day month year

Is the patient's medical condition expected to result in death? Yes ☐ No ☐

Does the patient's medical condition prevent them from working? Yes ☐ No ☐
If yes, please give the duration. ____/_____/_____/to ____/_____/_____/
day month year day month year

G. Additional Comments:

Signature: _____

Title: _____

License #: _____

MA Provider #: _____

Date: _____

Authorization to Release Information
Personal Physician, Hospital or Clinic

Claimant Name:_____ SSN:_____

Provider Name:_____

I hereby authorize the above named source to release any information to the local Department of Social Services and State Review Team all information concerning me including records, test results and my medical history. A photostatic copy of this authorization shall be valid as the original.

This information is being requested for the purposes of establishing eligibility for Medical Assistance benefits.

This authorization is effective for one year from the date below. It may be revoked at any time except to the extent that it has already been relied upon.

_____ _____

Signature of Claimant Date