

\_\_\_\_\_ 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 _____
_____	ICD-9-CM _____	Onset Date _____
_____	ICD-9-CM _____	Onset Date _____
_____	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 Abnormalities    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))

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**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	3hrs	4 hrs	5 hrs	6 hrs	7 hrs	8 hrs
Sit											
Stand											
Walk											
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/Odor				
Noise				
Height				

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

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The patient can use hands for repetitive action such as:

Hand Action	Yes	No	Unknown
Simple Grasping			
Pushing and 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 yes 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 on a sustained basis.

**Extreme** is defined as continuous and severe.

**FUNCTIONAL LIMITATIONS**

**DEGREE OF LIMITATIONS**

Restriction of Activities of Daily Living      None  Mild  Moderate  Marked  Extreme

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 \_\_\_\_/\_\_\_\_/\_\_\_\_/  
 month day year      month day 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 \_\_\_\_/\_\_\_\_/\_\_\_\_/  
 month day year      month day year

