REPORT OF MEDICAL EXAMINATION REQUESTED BY

_____COUNTY DEPARTMENT OF SOCIAL SERVICES

PART I. ***(To be completed by county DSS)*** Case No. _____Dist. No. _____

Patient Name _____DOB_____ SSN_____

Address _____

_____ _____

Date Case Manager / Telephone Number

PART II. ***(For Applicant, Recipient, Personal Representative or Guardian)***

I hereby authorize any physician, hospital, or clinic that has treated or examined me to give the County Department of Social Services information about my present or past health.

_____ _____

Date Signature of Applicant, Recipient,
Personal Representative, or Guardian

ALL INFORMATION BELOW IS TO BE COMPLETED BY A PHYSICIAN.

PART III. ***(Medical Report)*** Note to medical provider(s): The information you provide will be used by the County Department of Social Services to assist the individual in obtaining appropriate employment services, skills training, and/or medical treatment, which is consistent with the State and Federal Work Programs.

A. Does this individual have a medical or psychological condition(s) that results in functional limitations for work and/or attending training (i.e. work tolerance/stamina, mobility on the job, and communication with others)?

☐ YES ☐ NO (If answer is no, please sign and date on page two).

If answer is yes, please complete both pages.

B. Date and purpose of recent examination:

_____

_____

C. Diagnosis: _____ Date of Onset? _____

D. Prognosis: _____ Current Medications _____

E. Current Work Capacity: ☐ Full Time ☐ Part Time (No. of days per week) _____

Given the current medical condition and prescribed medications of the individual, list any existing work, driving, or training restrictions related to possible work or training activities:

_____

_____

Please select the work and training activities the individual can perform:

☐ Attend training classes number of hours per day_____

☐ Sitting number of hours per day_____

☐ Standing number of hours per day _____

☐ Bending number of hours per day _____

☐ Lifting number of hours per day _____

☐ Carrying number of hours per day _____

☐ Walking number of hours per day _____

☐ Understanding/Following Instructions

☐ Other, please specify _____

F. Please estimate how long this individual's condition will limit the capacity to *engage in any work or training.*

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days or more ☐ Permanent

☐ Other (Specify): _____

_____

G. Vocational Rehabilitation is an employment/training program designed for individuals with physical and mental limitations. Is your patient a candidate for referral to Vocational Rehabilitation? **DSS will make the referral.**

☐ YES ☐ NO
If "No" please explain. _____

_____

H. Additional comments regarding work capacity or functional limitations:

_____

_____

Reporting Physician's Name, Address, and Specialty ***(Please Type or Print)***	**Signature of Physician**
	Telephone No. _____ **Date of this report** _____