# BASIC MEDICAL



## SECTION I: IDENTIFYING INFORMATION TO BE COMPLETED BY WORKER

| Assistance Group Number | Recipient ID | DOB | Sex | County Name | | |
|---|---|---|---|---|---|---|
| Client Last Name | Client First Name | | MI | County Address | | |
| Client Address | Client Phone | | | City | | ZIP |
| City | ZIP | SSN | | Caseworker/Case Mgr | Caseload ID | County Phone |

## SECTION II: TO BE COMPLETED BY PHYSICIAN

Please send copies of all RELEVANT information supporting the medical conditions including reports of x-rays, scans, laboratory tests, consultant reports, hospital discharge summaries, etc.

Physical Examination / Vital Signs:

| | | | | |
|---|---|---|---|---|
| Height: | Weight: | Pulse Rate: | Blood Pressure: | Respiratory Rate: |
| HEENT: | | | Abdomen: | |
| Chest: | | | Heart: | |
| Extremities | | | Neurological: | |
| Visual Acuity: | OS: | OD: | | |
| ROM | Spine: | Joints: | | |
| A. Pregnancy verification only | | Date of test: | Expected date of delivery: | |

B. Describe the client's medical conditions (physical and mental) [Include appropriate ICD-9CM and/or DSM-IIIR codes(s)]

C. History of these problems (Onset, duration, treatment, prescribed medications, prognosis, etc.)

D. Health Status:

- □ Improving
- □ Improving Without Tx
- □ Improving With Tx
- □ Good/Stable With Tx
- □ Poor But Stable
- □ Deteriorating

E. Physical/psychological/psychiatric findings (Please also complete G and/or ODHS form 7308 for Mental Impairments as appropriate):

F: Are additional studies or treatment indicated? If yes, specify.

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| Client Last Name | Client First Name | MI | Recipient ID | SSN |
|---|---|---|---|---|
| | | | | |

**Considering the combined effects of the medical conditions noted above, please answer the following:**

G. Physical Functional Capacity Assessment

| | No | Yes | Hours |
|---|---|---|---|
| 1. Are standing/walking affected? | | | |
| If yes, how many hours in an 8-hour workday can patient stand/walk? | | | |
| How many hours without interruption? | | | |
| 2. Is sitting affected? | | | |
| If yes, how many hours in an 8-hour workday can patient sit? | | | |
| How many hours without interruption? | | | |
| 3. Are lifting/carrying affected? | | | |

If yes, up to how many pounds can patient lift/carry frequently? (up to 2/3 of 8 hour day)

□ Up to 5 lbs. □ 6-10 lbs □ 11-20 lbs □ 21-25 lbs. □ 26-50 lbs □ 51-100 lbs.

If yes, up to how many pounds can patient lift/carry occasionally? (up to 1/3 of 7 hour day)

□ Up to 5 lbs. □ 6-10 lbs □ 11-20 lbs □ 21-25 lbs. □ 26-50 lbs □ 51-100 lbs.

| | None | Not Significantly Limited | Moderately Limited | Markedly Limited | Extremely Limited |
|---|---|---|---|---|---|
| 4. Are the following functions affected? If so, how? | | | | | |
| Pushing/pulling | | | | | |
| Bending | | | | | |
| Reaching | | | | | |
| Handling | | | | | |
| Repetitive foot movements | | | | | |
| Seeing | | | | | |
| Hearing | | | | | |
| Speaking | | | | | |

5. What observations and/or medical evidence led to your findings in questions G1 - G4? Please provide examples of specific physical limitations:

After taking the appropriate history and performing the relevant physical examination, do you believe the client is: □ Employable □ Unemployable

How long are the physical and/or mental functional limitations listed above expected to last?

□ Less than 30 days □ Between 30 days and 9 months □ Between 9 months and 11 months □ 12 months or more

Will disclosure of this information to the client have an adverse effect? □ Yes □ No

| **Physician's Signature** | **Date of Last Exam** |
|---|---|
| | |

Physician's Name(Please print) Specialty

Address

| City | State | ZIP | | Physician's Phone |
|---|---|---|---|---|
| | | | | |