

MEDICAL REPORT FOR DETERMINATION OF DISABILITY

NEW YORK STATE

DEPARTMENT OF HEALTH

SECTION I – IDENTIFICATION (To Be Completed by Submitting Agency)

AGENCY'S NAME AND ADDRESS:	PATIENT'S NAME (<i>Last, First, Middle</i>):	CASE NUMBER:	
	PATIENT'S ADDRESS (<i>Street, City, State & Zip Code</i>):	SOCIAL SECURITY NUMBER:	
	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH:

SECTION II – MEDICAL REPORT – NOTICE TO PHYSICIAN

This individual has made an application (reapplication) for Disability Medicaid. Your cooperation in completing this form to show the individual's current condition, focusing on both remaining capabilities and limitations, is requested. Your promptness will ensure an early decision on the individual's application.

Please return the completed form to the agency in Section I above.

Diagnosis(es):	Date of last exam: _____
	Height: ____ ft. ____ in.
	Weight: _____ lbs.

Exertional Functions. Please indicate what the individual is CAPABLE of doing:

Lifting: <input type="checkbox"/> < 10 lbs. <input type="checkbox"/> Max. 10 lbs. <input type="checkbox"/> Max. 20 lbs./freq. 10 lbs. <input type="checkbox"/> Max. 50 lbs./freq. 25 lbs. <input type="checkbox"/> > 50 lbs.	Carrying: <input type="checkbox"/> < 10 lbs. <input type="checkbox"/> Max. 10 lbs. <input type="checkbox"/> Max. 20 lbs./freq. 10 lbs. <input type="checkbox"/> Max. 50 lbs./freq. 25 lbs. <input type="checkbox"/> > 50 lbs.	Standing: <input type="checkbox"/> < 2 hrs./day <input type="checkbox"/> 2 hrs./day <input type="checkbox"/> 6 hrs./day	Walking: <input type="checkbox"/> < 2 hrs./day <input type="checkbox"/> 2 hrs./day <input type="checkbox"/> 6 hrs./day	Sitting: <input type="checkbox"/> < 6 hrs./day <input type="checkbox"/> 6 hrs./day	Pushing: <input type="checkbox"/> Using R arm <input type="checkbox"/> Using L arm <input type="checkbox"/> Using R leg <input type="checkbox"/> Using L leg	Pulling: <input type="checkbox"/> Using R arm <input type="checkbox"/> Using L arm
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Non-Exertional Functions. Please check if LIMITATIONS exist in any of the areas below:

Sensory: <input type="checkbox"/> No Limitations <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Speaking	Postural: <input type="checkbox"/> No Limitations <input type="checkbox"/> Stooping/Bending <input type="checkbox"/> Crouching/Squatting <input type="checkbox"/> Climbing	Manipulative: <input type="checkbox"/> No Limitations <input type="checkbox"/> R Upper Extremity <input type="checkbox"/> L Upper Extremity
Environmental: <input type="checkbox"/> No Limitations <input type="checkbox"/> Tolerating dust, fumes, extremes of temperature <input type="checkbox"/> Tolerating exposure to heights or machinery <input type="checkbox"/> Operating a motor vehicle	Mental: <input type="checkbox"/> No Limitations <input type="checkbox"/> Understanding, carrying out, remembering instructions <input type="checkbox"/> Making simple work-related decisions <input type="checkbox"/> Responding appropriately to supervision, co-workers, work situations <input type="checkbox"/> Dealing with changes in a routine work setting	

Signature of Physician:	(Print Name):	Date Signed:
Specialty:	Office Address:	Office Phone Number: