Government of the District of Columbia
Department of Human Services
Income Maintenance Administration

For DHS Use Only

Worker:_____

Case #:_____

MRT Doctor Reviewer:_____

MEDICAL EXAMINATION REPORT

Customer/Patient Name:_____ Date of Birth:_____

Address:_____ Phone:_____

Physician's Name:_____ Address:_____

Agency:_____Phone:_____

The information provided in this form will be used to determine eligibility for benefits requiring a finding of disability under the Social Security disability criteria. Please focus your responses on the patient's ability to perform work functions.

Physical Examination Report *(To be completed by a medical professional):*

Date of exam: _____ Height:_____ Weight: _____

Medical Conditions, Clinical Manifestations, and Diagnosis:
(*Please include ICD-9 Codes or DSM-IV Codes and avoid abbreviations as much as possible*):

_____
_____
_____
_____
_____
_____
_____

Describe Objective Findings, Clinical Findings and your treatment recommendations:
(Especially since we do not see the individual and need your observations. Please include all of the patient's positive test results and signs found during examination.):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Functional Limitations	**Degree of Limitation**				
Restrictions 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, and/or Pace	None ☐	Mild ☐	Moderate ☐	Marked ☐	Extreme ☐
Repeated episodes of decompensation in work or work like settings, each of an extended duration	None ☐	Mild ☐	Moderate ☐	Marked ☐	Extreme ☐

Physical Capacities	Less than 2 hours	At least 2 hours	About 6 hours
Sit			
Stand			
Walk			

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

Evaluation: Based upon your evaluation**,** has your patient's medical condition lasted, or can it be expected to last, at least 12 months? **Yes** ☐ **No** ☐
Is the patient's medical condition expected to result in death? **Yes** ☐ **No** ☐
Does the patient's medical condition prevent him/her from working? **Yes** ☐ **No** ☐
If yes, please give the duration**:** Day___ Month___ Year___ to Day___ Month___ Year___

Remarks: (Please provide any additional information clarifying how the patient's condition limits his or her ability to work. If possible, include a description of any restrictions in Activities of Daily Living, and/or Social Functioning, and/or Concentration, Persistence, and/or Pace due to the patient's condition):

_____
_____
_____
_____
_____
_____
_____

Please attach records or other additional medical or mental health evidence.

Signature of Medical Provider Printed Name of Medical Provider Date

(proposed rev. 08/04)