DC | DEPARTMENT of HUMAN SERVICES

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
ECONOMIC SECURITY 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 Manifesations, and Diagnosis:
(Please include current ICD Codes or DSM Codes and avoid abbreviations as much as possible):

Describe Objective Findings, Clinical Findings and your treatment recommendations:
(We do not see the patient and require your observations. Please include all of the patient's positive test results and clinical 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	3-5 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 patiens can lift/carry frequently:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 25 lbs ☐ 50 lbs ☐ 100 lbs ☐ more than 100 lbs

Evaluation: Based upon your evaluation, has your patient's medical condition lasted, or can it be expected to last, at leat 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 Licensed Physician | Specialty | Printed Name of Licensed Physician | Date

(DHS 856 rev. 09/17)

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SOCIAL INFORMATION: MEDICAL REVIEW

NAME: ..... **PHONE:** ..... **BIRTHDATE:** .....

PART A: (To be completed by customer or representative) **Today's Date:** .....

1. Your usual job: .....

2. Highest grade you completed in school: ..... If you have any special training or skills please give a description: .....

..... Are you currently in a training program? .....

Are you interested in training? ..... Why? .....

.....

3. Why do you feel you are unable to work? (Statement of illness; how it affects ability to work.) .....

.....

4. **HOW HAVE YOU MANAGED UP TO NOW** (Include past periods getting TANF and also how you got by when unemployed.)

Type of work (starting with your last job)	Describe the duties and activities of the job	DATES From	To	Why did you leave this job?

5. YOUR CURRENT MEDICAL TREATMENT

What health problem?	*What doctor, clinic or hospital*	*Last Appointment/ Next Appt.*
.....	.....	.....
.....	.....	.....
.....	....	.....

6. IF YOU STAYED IN THE HOSPITAL

What was it for? (Starting with your last stay)	*When was it?*
.....	.....
.....	.....

Customer's Name: .....

PART A was completed by:
☐ Customer/Patient ☐ SSR/Case Manager ☐ Telephone Contact ☐ Other .....

PART B (to be completed by SSR/Case Manager)

1. Is current medical report from patient's treating facility/doctor? If no, explain why not: .....

.....

.....

.....

2. From your contact with and observation of the customer, describe any physical, mental, and/or social factors you feel might impair the customer's ability to support self.

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3. **CUSTOMER'S STATUS WITH REHABILITATION/TREATING FACILITIES**
(List if active at time of application and/or actions taken on team recommendations at time of review.)

Name of Agency/Facility/Clinic	Date Referred	ACTIVE	NOT ACCEPTED OR CASE CLOSED
.....	.....	☐	☐
.....	.....	☐	☐
.....	.....	☐	☐

Has customer refused or failed to follow through with training or treatment? ..... If yes, explain: .....

.....

.....

4. **REMARKS:**

SSR/Case Manager: ..... Date: .....