



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MEDICAL REPORT INCLUDING PHYSICIAN'S CERTIFICATION/DISABILITY EVALUATION

CASE NAME (FIRST)	(MIDDLE)	(LAST)	CASE DCN	COUNTY
INDIVIDUAL NAME (FIRST)	(MIDDLE)	(LAST)	INDIVIDUAL DCN	DATE OF BIRTH (MM/DD/YYYY)
ELIGIBILITY SPECIALIST	ELIG SPEC NUMBER	LOAD	DATE OF APP/REAPP	DATE SUBMITTED TO MRT

TO THE EXAMINING PHYSICIAN

The above named person is applying for or is a member of a household which is applying for public assistance based on disability. Eligibility for assistance will be based, in part, on the medical information which you supply on this form. Therefore, please complete the entire form as thoroughly and accurately as possible. We need to know if this person has a mental or physical disability which makes him/her unable to function at his/her normal occupation or other suitable employment. After an examination has been completed and/or the medical information entered on the form, your opinion is needed about the person's mental and/or physical condition with regard to employability.

NOTE: The Family Support Division **will not** assume responsibility for payment of inpatient costs unless **prior** written authorization is given by the County Manager of the Family Support Division office that initiated this form. If you feel that hospitalization is required before you can make a decision regarding employability, indicate this on the form and return it to the Family Support Division County Office.

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

ARE YOU NOW OR HAVE YOU TREATED THIS PATIENT IN PAST YEAR?
 YES NO IF YES, DATE

BRIEF CLINICAL HISTORY (CHIEF COMPLAINTS)

HAS PATIENT BEEN HOSPITALIZED WITHIN THE PAST YEAR? HOSPITAL
 NO YES IF YES ▶

COMPLETE FOR EACH PERSON		BLOOD PRESSURE		HGB OR HCT IF INDICATED		URINALYSIS	
WEIGHT	HEIGHT	SYSTOLIC	DIASTOLIC	HGB	HCT	SUGAR	ALBUMEN
EYES		VISION CORRECTED BY GLASSES TO				EARS HEARING (ORDINARY CONVERSATION)	
RIGHT	LEFT	RIGHT	LEFT	RIGHT (20 FT.)	LEFT (20 FT.)		

NOSE, THROAT, MOUTH, NECK (ABNORMALITIES)

CARDIOVASCULAR SYSTEM

CARDIAC ENLARGEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	DEGREE	MURMURS	RHYTHM		
EVIDENCE OF CARDIAC DECOMPENSATION (IF YES, EXPLAIN) <input type="checkbox"/> YES <input type="checkbox"/> NO	EVIDENCE OF BASILAR RALES (IF YES, EXPLAIN) <input type="checkbox"/> YES <input type="checkbox"/> NO				
EVIDENCE OF LIVER ENLARGEMENT (IF YES, EXPLAIN) <input type="checkbox"/> YES <input type="checkbox"/> NO	EVIDENCE OF PERIPHERAL EDEMA (IF YES, EXPLAIN) <input type="checkbox"/> YES <input type="checkbox"/> NO				
ANGINA PECTORIS? IF YES, DESCRIBE PAIN AND AMOUNT OF EXERTION REQUIRED TO PRODUCE IT. <input type="checkbox"/> YES <input type="checkbox"/> NO					
PULSE RATE	DYSPNEA	CYANOSIS	EDEMA	TYPE OF HEART DISEASE	FUNCTIONAL CLASSIFICATION
PERIPHERAL ARTERIAL DISEASE? (IF YES, EXPLAIN) <input type="checkbox"/> YES <input type="checkbox"/> NO			ABSENT PULSATION? (IF YES, EXPLAIN) <input type="checkbox"/> YES <input type="checkbox"/> NO		
VARICOSITIES? (IF YES, EXPLAIN) <input type="checkbox"/> YES <input type="checkbox"/> NO					

PULMONARY FUNCTION

RIGHT	LEFT
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NERVOUS SYSTEM

PARALYSIS, SPEECH, GAIT, REFLEXES: PUPILLARY, KNEE, BABINSKI, ROMBERG

EVIDENCE OF
 PSYCHOSIS NEUROSIIS MENTAL DEFICIENCY DESCRIBESEIZURES
 NO YES IF YES ▶ TYPE FREQUENCY OF ATTACKS WITH MEDICATION**NEOPLASMS**

SITE BENIGN MALIGNANT METASTASES

BONES, JOINTS, AND EXTREMITIESDESCRIBE DISEASE OR INJURY AND STATE LIMITATION OF MOTION, SUCH AS ABILITY TO WALK, STAND, BEND, STOOP, GRASP, ETC.

_____**ABDOMEN** SCARS TENDERNESS PALPABLY ENLARGED ORGANS HERNIA DESCRIBE ITEMS CHECKED**GENITO-URINARY** URETHRAL DISCHARGE HYDROCELE EPIDIDYMITIS DESCRIBE ITEMS CHECKED
 PROSTATE ABNORMAL TESTICAL**GYNECOLOGICAL** PROLAPSE CYSTOCELE RECTOCELE CERVIX ADNEXA PREGNANT, EXPECTED DUE DATE: _____

DESCRIBE ITEMS CHECKED

ANO-RECTAL HEMORRHOIDS PROLAPSE FISSURES FISTULA DESCRIBE ITEMS CHECKED

OTHER LABORATORY FINDINGS (ATTACH WRITTEN REPORT OF X-RAYS, EKG, OR OTHER LABORATORY FINDINGS)

DIAGNOSIS

PRIMARY

SECONDARY

KNOWN MEDICATIONS

SUMMARIZE THE FINDINGS WITH EMPHASIS ON FUNCTIONAL CAPACITY

_____IS FURTHER DIAGNOSTIC EXAMINATION INDICATED? TYPE
 YES NO**DETERMINATION OF INCAPACITY:** In my opinion this individual (does does not) have a mental and/or physical disability which prevents him/her from engaging in that employment or gainful activity for which his/her age, training, experience or education will fit him/her. When evaluating a child, the physical or mental impairment has to compare in severity to an impairment that would make an adult disabled and evidence of marked restriction in daily age appropriate activities must exist.**DURATION OF INCAPACITY:** In my opinion, the expected duration of disability/incapacity will be:
 1 month 3-5 months 13 or more months
 2 months 6-12 months permanent**THE ABOVE FINDINGS AND STATEMENTS ARE BASED ON MY EXAMINATION AND/OR RECORDS.**

SIGNATURE OF PHYSICIAN DATE