**REPORT OF MEDICAL EXAMINATION REQUESTED BY**

**_____COUNTY SOCIAL/HUMAN SERVICES AGENCY**

**PART I.** ***(To be completed by county agency)*** ICS No. _____ PDC No. _____

Patient Name _____ DOB_____ SSN: XXX-XX- _ _ _ _ ***(last four digits only)***

Address _____

| _____ | _____ | _____ |
|---|---|---|
| **Date** | **Case Manager's Name** | **Telephone No.** |

**Please read this form carefully, and ask questions if you do not understand.**

**PART II. (For Applicant, Recipient, Personal Representative or Guardian*)***

I, _____ hereby authorize any physician, hospital, or clinic that has treated or examined
***Print Name***

_____, to provide information to the county social/human services agency about their
***Print Patient's Name***

current or past health. This consent is voluntary and remains valid for a period of up to one year. I also understand I may cancel the consent at any time by contacting the agency. The cancellation does not affect information already shared. I also understand that I may refuse to sign this authorization.

Signature _____ Relationship to Patient _____Date_____

**ALL INFORMATION BELOW IS TO BE COMPLETED BY A PHYSICIAN.**

**PART III. Note to medical provider(s):** The information you provide will be used by the county human/social services agency to assist the individual in obtaining appropriate employment services, skills training, and/or or other services, which are consistent with the State and Federal programs.

**A.** Does this individual have a medical or psychological condition(s) that results in functional limitations for work and/or attending training (i.e. work tolerance/stamina, mobility on the job, and communication with others)?

☐ YES ☐ NO (If answer is no, please sign and date Page 2).

**If answer is yes, please complete both pages.**

**B.** Date and purpose of most recent medical examination:

_____

**C.** Diagnosis: _____ Onset Date: _____

**D.** Current Work Capacity: ☐ Full Time ☐ Part Time (No. of days per week) _____

**E.** **Given the current medical condition and prescribed medications of the individual, list any existing work, driving, or training restrictions related to possible work or training activities**:

_____

_____

**Please select the work and training activities the individual can perform:**

☐ Attend training classes number of hours per day_____

☐ Sitting number of hours per day_____

☐ Standing number of hours per day _____

☐ Bending number of hours per day _____

☐ Lifting number of hours per day _____

☐ Carrying number of hours per day _____

☐ Walking number of hours per day _____

☐ Understanding/Following Instructions

☐ Other, please specify _____

**F.** Please estimate how long this individual's condition will limit the capacity to *engage in any work or training.*

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days or more ☐ Permanent

☐ Other (Specify): _____

_____

**G.** Vocational Rehabilitation is an employment/training program designed for individuals with physical and mental limitations. Is your patient a candidate for referral to Vocational Rehabilitation? ***(The county social/human services agency will make the referral.)***

☐ YES ☐ NO

If "No" please explain. _____

_____

**H.** Additional comments regarding work capacity or functional limitations:

_____

_____

| **Reporting Physician's Name, Address, and Specialty** ***(Please Type or Print)*** | **Signature of Physician and Date:** |
|---|---|
| | **Telephone No.** _____<br>**Fax No.** _____<br>**E-mail Address:** _____ |