MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MEDICAL REPORT INCLUDING PHYSICIAN'S CERTIFICATION/DISABILITY EVALUATION

INDIVIDUAL NAME (FIRST)	(MIDDLE)	(LAST)	INDIVUDIAL DCN	DATE OF BIRTH	COUNTY

ELIGIBILITY SPECIALIST	FAMIS USER ID	LOAD	DATE OF APP/REAPP/REVIEW	DATE SUBMITTED TO MRT

TO THE EXAMINING PHYSICIAN | Physician's Name: | Specialty:

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 that 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 THE PAST YEAR? ☐ YES ☐ NO IF YES, DATE

BRIEF CLINICAL HISTORY (CHIEF COMPLAINTS)

HAS PATIENT BEEN HOSPITALIZED WITHIN THE PAST YEAR?
☐ NO ☐ YES IF YES, ENTER NAME OF HOSPITAL ►

HOSPITAL

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? ☐ YES ☐ NO	DEGREE	MURMURS	RHYTHM

EVIDENCE OF CARDIAC DECOMPENSATION ☐ YES ☐ NO BASILAR RALES ☐ YES ☐ NO LIVER ENLARGEMENT ☐ YES ☐ NO
PERIPHERAL EDEMA ☐ YES ☐ NO IF YES, PLEASE EXPLAIN.

ANGINA PECTORIS? ☐ YES ☐ NO DESCRIBE PAIN AND AMOUNT OF EXERTION REQUIRED TO PRODUCE IT.

PULSE RATE	DYSPNEA	CYANOSIS	EDEMA	TYPE OF HEART DISEASE	FUNCTIONAL CLASSIFICATION

PERIPHERAL ARTERIAL DISEASE? ☐ YES ☐ NO IF YES, EXPLAIN

ABSENT PULSATION? ☐ YES ☐ NO IF YES, EXPLAIN

VARICOSITIES? ☐ YES ☐ NO IF YES, EXPLAIN

PULMONARY FUNCTION	RIGHT	LEFT

NERVOUS SYSTEM

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

EVIDENCE OF ☐ PSYCHOSIS ☐ NEUROSIS ☐ MENTAL DEFICIENCY	DESCRIBE

SEIZURES ☐ NO ☐ YES IF YES, LIST ►	TYPE	FREQUENCY OF ATTACKS WITH MEDICATION

NEOPLASMS

SITE	BENIGN	MALIGNANT	METASTASES

BONES, JOINTS, AND EXTREMITIES

DESCRIBE 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	☐ PROSTATE	☐ ABNORMAL TESTICAL

DESCRIBE ITEMS CHECKED

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 (physical) : Diagnosis and GAF (Global Assessment of Functioning): (mental health)

PRIMARY

SECONDARY

KNOWN MEDICATIONS

SUMMARIZE FINDINGS WITH EMPHASIS ON FUCTIONAL CAPACITY

IS FURTHER DIAGNOSTIC EXAMINATION INDICATED? ☐ YES ☐ NO	TYPE

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 (Please print physician's name beneath signature)	**DATE**