State of Illinois
Department of Human Services

Medical Evaluation - Physician's Report

Date: ______________________

189ca752-3a1f-4f6c-b39f-5e6261243652

Case Number: ______________________

Office Name: ______________________

Office Address: ______________________

____

Phone: ______________________

TTY: ______________________

Fax: ______________________

NAME: ______________________
ADDRESS: ______________________
ADDRESS: ______________________
CITY, ST. ZIP ______________________

Tenemos este aviso en español. Para solicitar avisos en español, por Internet vaya al sitio ABE-MMC o llame al 1-800-843-6154 (TTY 1-866-324-5553 TTY/ Nextalk, 711 TTY Relay).

You can manage your account online at abe.illinois.gov

Physical Assessment: MEDICAL PROVIDER - Please Complete the Following Sections
The medical Information will help us determine if your patient is eligible for medical assistance or other public assistance.
In order to evaluate your patient, we ask that you provide us with a copy of your office progress notes, test results, x-ray reports, and any other relevant medical records for the past 12 months.
Please complete the SECTION 1 and any of the following sections that relate to your patient's diagnosis, symptoms and complaints. **YOUR OPINION ON YOUR PATIENT'S ABILITY TO PERFORM WORK RELATED ACTIVITIES IN SECTION 3 and 4 IS VERY IMPORTANT.** Please return this completed form to: ______________________

SECTION 1:

Date Last Examined: __________ Date First Seen: __________ Frequency of Visits: __________

Number of Hospitalizations in last 12 months: __________

Approximate Dates	Where Hospitalized	Reason Hospitalized

Height: ______ Weight: ______ BMI: ______ Blood Pressure: ______ Pulse: ______ Respiratory Rate: ______

General Appearance:

Chief Complaints of Patient and Dates of Onset:

Complete Diagnosis (for mental impairments, include DSM Code if known):

Significant Lab Tests (list dates and results):

H/H: __________ Sed Rate: __________ ANA: __________ RF: __________

Creatinine: __________ Bilirubin: __________ Other: __________

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SECTION 2: Case Number: ______________________ 189ca752-3a1f-4f6c-b39f-5e6261243652

1.Vision

Left Visual Acuity: ________ Right Visual Acuity: ________ * Left Corrected: ________ * Right Corrected: ________
(* measured with current manifest refraction)

Date of Examination: ________ Any Pathology: ______________________

2.Hearing

Left: ________ Right: ________ Test Results (include date of test and copy of test): ________

Air Conduction Left ________ Air Conduction Right ________

Bone Conduction Left ________ Bone Conduction Right ________

Cochlear implant: ◯ Yes ◯ No Date : ________ Aided: ◯ Yes ◯ No

3.Cardiovascular System

Heart Size: ________ Sounds: ________ Rate/Rhythm: ________

Chest Pains (describe): ________ Dyspnea: ________

Syncope (describe): ______________________

Peripheral Pulses: ________ Edema: ________

Treatment/Prescription: ______________________

Response: ______________________

EKG Findings (list dates and include copies of tracings): ______________________

AHA Cardiac Functional Capacity ◯ 1 ◯ 2 ◯ 3 ◯ 4 Ejection Fraction: ________ Date: ________

EF obtained from ◯ Cardiac Catheterization ◯ Muga ◯ Echo cardiogram (submit report)

EF done during a period of ◯ stability or ◯ exacerbation

Other Test Results (include dates): ______________________

4.Respiratory System

Describe clinical signs (e.g., wheezing, rhonchi, prolonged expiration, etc.):

Pulmonary Function Study Date: ________ During a period of ◯ stability or ◯ exacerbation

Pre-bronchodilator: FVC ________ FEV1 ________ DLCO ________ O2 sat on room air: ________

Post-bronchodilator: FVC ________ FEV1 ________

Treatment/Prescriptions: ______________________

Response: ______________________

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5.Digestive System Case Number: ______________________ 189ca752-3a1f-4f6c-b39f-5e6261243652

Objective Findings (if wt. loss, describe): ______________________

Test Results (show dates): ______________________

Treatment/Prescription: ______________________

Response: ______________________

6.Genitourinary System

Objective Findings: ______________________

EDD: __________ Pregnancy complications (include dates): ______________________

Test Results (show dates): ______________________

Treatment/Prescription: ______________________

Response: ______________________

7.Endocrine System

Objective Findings: ______________________

Test Results (show dates): ______________________

Treatment/Prescription: ______________________

Response: ______________________

For diabetes mellitus, indicate frequency of acidotic episodes, presence of neuropathy, retinitis, etc.:

____

8.Hemic and Lymphatic System

Objective Findings: ______________________

Test Results (show dates): ______________________

Treatment/Prescription: ______________________

Response: ______________________

9.Neoplastic Disease (attach pathology reports)

Origin: __________ Metastasis ◯ Yes ◯ No Site: __________

Treatment/Prescription: ______________________

Response: ______________________

Prognosis: ______________________

Secondary Complications: ______________________

10.HIV Infection and Immune System

Serological Test for AIDS: Type: __________ Result: __________ Date: __________

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10.HIV Infection and Immune System (continued)

Opportunistic Infections (identify): ____________________
Other related diseases: ____________________
Other symptoms: ____________________
Treatment/Prescription: ____________________
Response: ____________________

11.Neurological System

If seizure disorder exists, indicate frequency: __________ Seizure medication blood level and date: __________
Describe seizure in detail (if multiple types of seizures, note frequency and description of each type):

Treatment/Prescription: ____________________ Compliant? : ◯ Yes ◯ No
Response to Treatment: ____________________
Stroke: __________ Date: __________ Sequela: ____________________
List other neurological impairments (e.g., gait, station, balance, etc.): ____________________
Describe any deficiencies in hand manipulation and/or weakness of the upper or lower extremities (if applicable):

12.Musculoskeletal System

Describe any pain, swelling, tenderness, stiffness, or crepitus (including location, frequency and specific findings):

Describe loss of joint motion (indicate joint and describe range of motion in degrees from neutral position):

Describe any deficiencies in hand manipulation and/or weakness of the upper or lower extremities (if applicable):

Describe x-ray findings (include dates): ____________________
Other objective findings: ____________________
Treatment / Prescription: ____________________
Response: ____________________

13.Skin:

Describe location of lesions, onset and response to treatment:

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SECTION 3: MEDICAL REVIEW OF THE ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

- **REGULAR AND CONTINUOUS BASIS** means 8 hours a day, for 5 days a week, or the equivalent
- **OCCASIONALLY** means very little to one-third of the time
- **FREQUENTLY** means from one-third to two thirds of the time
- **CONTINUOUSLY** means more than two-thirds of the time

Age and body habitus of the individual should not be considered in the assessment of limitations.

Lift

	Never	Occasionally	Frequently	Continuously
< 10 lbs	☐	☐	☐	☐
10 lbs	☐	☐	☐	☐
25 lbs	☐	☐	☐	☐
50 lbs	☐	☐	☐	☐
100 lbs	☐	☐	☐	☐

Carry

	Never	Occasionally	Frequently	Continuously
< 10 lbs	☐	☐	☐	☐
10 lbs	☐	☐	☐	☐
25 lbs	☐	☐	☐	☐
50 lbs	☐	☐	☐	☐
100 lbs	☐	☐	☐	☐

MOBILITY

SITTING/STANDING/WALKING AT ONE TIME WITHOUT INTERRUPTION

	Minutes	Hours							
a. Sit	________	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
b. Stand	________	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
c. Walk	________	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Does the individual require the use of a cane/walker/other appliance to ambulate? ◯ Yes ◯ No

How far can the individual ambulate without the use of this device? ______________________

- Without this support, can the individual use his/her free hand to carry small objects? ◯ Yes ◯ No

USE OF HANDS - Indicate how often the individual can perform the following activities:

Occasionally = up to 1/3   Frequently = 1/3 to 2/3   Continuously = over 2/3

Right Hand

	Never	Occasionally	Frequently	Continuously
Reaching Overhead	☐	☐	☐	☐
Reaching All Other	☐	☐	☐	☐
Handling	☐	☐	☐	☐
Fingering	☐	☐	☐	☐
Feeling	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐

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USE OF HANDS - Indicate how often the individual can perform the following activities: (continued)

Left Hand

	Never	Occasionally	Frequently	Continuously
Reaching Overhead	☐	☐	☐	☐
Reaching All Other	☐	☐	☐	☐
Handling	☐	☐	☐	☐
Fingering	☐	☐	☐	☐
Feeling	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐

USE OF FEET - Indicate how often the individual can perform the following activities:

Occasionally = up to 1/3 Frequently = 1/3 to 2/3 Continuously = over 2/3

Right Foot	Never	Occasionally	Frequently	Continuously
Operating foot controls	☐	☐	☐	☐

Left Foot	Never	Occasionally	Frequently	Continuously
Operating foot controls	☐	☐	☐	☐

Postural Activities - How often can the individual perform the following activities:

Occasionally = up to 1/3 Frequently = 1/3 to 2/3 Continuously = over 2/3

	Never	Occasionally	Frequently	Continuously
Climb stairs and ramps	☐	☐	☐	☐
Climb ladders / scaffolds	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐

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ENVIRONMENTAL LIMITATIONS - How often can the individual tolerate exposure to the following conditions:

	Never	Occasionally	Frequently	Continuously
Unprotected Heights	☐	☐	☐	☐
Moving Mechanical Parts	☐	☐	☐	☐
Humidity and wetness	☐	☐	☐	☐
Dust, odors, fumes	☐	☐	☐	☐
Pulmonary irritants	☐	☐	☐	☐
Extreme cold	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
Vibrations	☐	☐	☐	☐
Other (specify) ________	☐	☐	☐	☐

	Quiet (Library)	Moderate (Office)	Loud (Heavy Traffic)	Very Loud (Jack Hammer)
Noise	☐	☐	☐	☐

Do any of the impairments affect the individual's hearing or vision?

☐ No ☐ Yes ☐ Not Evaluated If “yes” please complete the following questions (where appropriate)

1.If a hearing impairment is present:

a. Does the individual retain the ability to hear and understand simple oral instructions and to communicate simple information? ☐ Yes ☐ No

b. Can the individual use a telephone to communicate? ☐ Yes ☐ No

2. If a visual impairment is present:

a. Is the individual able to avoid ordinary hazards in the workplace, such as boxes on the floor, doors ajar, or approaching people or vehicles? ☐ Yes ☐ No

b. Is the individual able to read very small print? ☐ Yes ☐ No

c. Is the individual able to read ordinary newspaper or book print? ☐ Yes ☐ No

d. Is the individual able to view a computer screen? ☐ Yes ☐ No

e. Is the individual able to determine the differences in shape and color of small objects such as screws, nuts, or bolts? ☐ Yes ☐ No

PLEASE PLACE A CHECK IN APPROPRIATE BOXES BASED SOLEY ON THE PERSON'S PHYSICAL IMPAIRMENT.

1.Can the individual perform activities like shopping unassisted? ☐ Yes ☐ No

2.Can the individual travel without a companion for assistance? ☐ Yes ☐ No

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PLEASE PLACE A CHECK IN APPROPRIATE BOXES BASED SOLEY ON THE PERSON'S PHYSICAL IMPAIRMENT.

3.Can the individual walk a block at a reasonable pace on rough or uneven surface? ☐ Yes ☐ No

4.Can the individual use standard public transportation? ☐ Yes ☐ No

5.Can the individual climb a few steps at a reasonable pace with the use of a single hand rail? ☐ Yes ☐ No

6.Can the individual prepare a simple meal and feed himself/herself? ☐ Yes ☐ No

7.Can the individual care for personal hygiene? ☐ Yes ☐ No

8.Can the individual sort, handle, use paper/files? ☐ Yes ☐ No

State any other work-related activities, which are affected by any impairment, and indicate how the activities are affected. Examples would be a need to lie down during the work day, a need to be absent from their job or a need to shift at will.

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc) which support your assessment of any limitations and why the findings support the assessment. It is important that you relate particular medical or clinical findings to any assessed limitations in capacity. The usefulness of your assessment depends on the extent to which you do this.

THESE LIMITATIONS ABOVE ARE ASSUMED TO BE YOUR OPINION REGARDING CURRENT LIMITATIONS ONLY.

HOWEVER, IF YOU HAVE SUFFICIENT INFORMATION TO FORM AN OPINION WITHIN A REASONABLE DEGREE OF MEDICAL PROBABILITY AS TO PAST LIMITATIONS, ON WHAT DATE WERE THE LIMITATIONS YOU FOUND ABOVE FIRST PRESENT? MONTH __________ YEAR __________

HAVE THE LIMITATIONS YOU FOUND ABOVE LASTED OR WILL THEY LAST FOR 12 CONSECUTIVE MONTHS? ☐ Yes ☐ No

SECTION 4: MEDICAL REVIEW OF THE ABILITY TO DO WORK-RELATED ACTIVITIES (Mental)

For each activity shown below, respond to the questions about the individual's ability to do work-related activities on a sustained basis (8 hours a day five days a week or the equivalent) using the following definitions for the rating terms:

- **None** -Absent or minimal limitations (transient or expected reactions to psychological stresses).
- **Mild** -There is a slight limitation in this area, but the individual can generally function well.
- **Moderate** -There is more than a slight limitation but the individual functions satisfactorily.
- **Marked** -There is serious limitation with a substantial loss in the ability to effectively function.
- **Extreme** -There is major limitation in this area. There is no useful ability to function in this area.

1.Understand and remember simple instructions ☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Extreme

2.Carry out simple instructions ☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Extreme

3.Ability to make judgments on simple tasks ☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Extreme

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SECTION 4: MEDICAL REVIEW OF THE ABILITY TO DO WORK-RELATED ACTIVITIES (Mental) (continued)

4.Carry out complex instructions	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Extreme
5.Ability to make judgments on complex decisions	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Extreme
6.Interact appropriately with the public	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Extreme
7.Interact appropriately with supervisor(s)	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Extreme
8.Interact appropriately with co-workers	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Extreme
9.Respond appropriately to usual work situations and to changes in a routine work setting	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Extreme

10.Other capabilities affected by the impairment? ☐ Yes ☐ No
Please identify the capability and describe how it is affected.

Identify the factors (e.g., the particular medical signs, laboratory findings, or other factors described above) that support your assessment. It is important that you relate particular medical or clinical findings to any assessed limitations in capacity. The usefulness of your assessment depends on the extent to which you do this.

11. The limitations above are assumed to be your opinion regarding current limitations only. However, if you have sufficient information to form an opinion within a reasonable degree of medical or psychological probability as to past limitations, on what date were the limitations you found first present? ______________________

12. If the claimant's impairment(s) include alcohol and/or substance abuse, do these impairments contribute to any of the claimant's limitations as set forth above? If so, please identify and explain what changes you would make to your answer if the claimant was totally abstinent from alcohol and/or substance use/abuse.

Medical Provider Signature: ______________________________ Date of Examination: ____________________

Printed Name of Medical Provider: ______________________________ Telephone Number: ____________________

Medical Specialty: ____