MEDICAL EXAMINATION FOR EMPLOYABILITY ASSESSMENT, DISABILITY SCREENING, AND ALCOHOLISM/DRUG ADDICTION DETERMINATION

I. CLIENT IDENTIFICATION

Print Client Name: ______________________________ Veteran: ☐ Yes ☐ No

Address: ____

Case #: ____________________ CIN: _____________________ DOB: _____________________

Reason(s) for referral: Client states that:____

____

II. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the examining physician to disclose to the Department of Social Services any information provided, any diagnoses made, conditions revealed, and functional limitations identified, as a result of the examination given. I understand that this information will be treated as confidential.

Client Signature **x** ______________________________ Date: _________________

AUTORIZACION PARA DAR A CONOCER INFORMACION MEDICA

Yo autorizo al médico que me está examinando a dar a conocer al Departamento de Servicios Sociales cualquier información provista, cualquier diagnosis, condiciones reveladas y limitaciones funcionales identificadas en base al examen realizado. Comprendo que esta información será confidencial.

Firma del Cliente **x** ______________________________ Fecha: ________________

III. MEDICAL INFORMATION

List All Medical Conditions. Include psychiatric and alcohol/drug addiction diagnosis using DSM-IV format. (List all medical diagnoses and specify medical/clinical findings, including prognoses and how long each condition is expected to last.)

Medical Condition	**Prognosis and Treatment Recommendations including prescribed medications**	**Date of original diagnosis/diagnosis type**	**Expected Duration From Present (Months)**
		Date: ☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐1-3 ☐4-6 ☐7-11 ☐12+ ☐Permanent
		Date: ☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐1-3 ☐4-6 ☐7-11 ☐12+ ☐Permanent
		Date: ☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐1-3 ☐4-6 ☐7-11 ☐12+ ☐Permanent
		Date: ☐ Physical Health ☐ Mental Health ☐ Substance Use Disorder ☐ Other	☐1-3 ☐4-6 ☐7-11 ☐12+ ☐Permanent

IV. FUNCTIONAL LIMITATIONS (related to medical findings noted in Section III): *(check column that applies)*

a.) Physical Functioning	No. Evidence of Limitations	Moderately Limited	Very Limited	b.) Mental Functioning	No. Evidence of Limitations	Moderately Limited	Very Limited
Walking				Understands and remembers instructions			
Standing				Carries out instructions			
Sitting				Maintains attention/concentration			
Lifting, Carrying				Makes simple decisions			
Pushing, Pulling, Bending				Interacts appropriately with others			
Seeing, Hearing, Speaking				Maintains socially appropriate behavior without exhibiting behavior extremes			
Using Hands				Maintains basic standards of personal hygiene and grooming			
Stairs or other climbing				Appears able to function in a work setting at a consistent pace			
Other:				Other:			

V. TREATMENT HISTORY (list for medical, psychiatric, alcoholism and drug treatment for the past Two Years)

Name of Program/Provider	Type of Program/Provider i.e. Outpatient, Residential, Methadone (for addiction specify modality)	Length of Treatment (# of Months)

VI. CURRENT TREATMENT PROGRAM IDENTIFICATION (include medical, psychiatric, alcoholism and drug treatment as applicable.)

Program Name: _____

Address of Client's Treatment Site: _____

Mailing Address (If different from above): _____

Treatment Program Contact: _____ Title: _____

Telephone #: ( ) _____ Fax #: ( ) _____

VII. LIMITATIONS ON WORK ACTIVITIES

a. Taking into consideration physical, mental and addiction limitation(s), describe any working conditions, environments, or work activities which are contraindicated: _____

_____

b. Are these restrictions expected to last: ☐ 1-3 months ☐ 4-6 months ☐ 7-11 months ☐ 12+ months ☐ permanent

c. Do you recommend referral to rehabilitation, including but not limited to, a mental health or alcohol/substance abuse, or a physical rehabilitiation program? ☐ Yes ☐ No If yes, please specify: _____

VIII. SCREENING FOR POSSIBLE SSI REFERRAL

Based on the evidence available to you, does this individual have severe impairment(s) which has lasted, or is expected to last at least 12 months? IF YES, *please check* _____ Explain briefly: _____

_____ If substance abuse is also found, would such impairment be expected to continue if use of drugs and/or alcohol were to cease? ☐ Yes ☐ No

IX. PHYSICIAN INFORMATION

Physician's or Psychologist's Name *(please print)*: _____

Address: _____

Board eligible or certified specialty: _____ Tele.#: ( ) _____ Fax #: ( ) _____

Is this client a patient of the examining physician? ☐ Yes ☐ No If yes, for how long? _____

Date of Last Examination: _____

Signature of physician or psychologist: **X** _____ Date: _____

Please forward this completed form to Social Services Contact: _____

Telephone #: _____ Address: _____