INSTRUCTIONS FOR PHYSICIAN/LICENSED PSYCHIATRIC CLINIC IN COMPLETING REPORT OF PHYSICAL/MENTAL EXAMINATION (PA 586)

Section II. Complete as indicated.

Section III. Medical information is required by the county assistance office (CAO) in determining whether a person qualifies for a certain category of assistance and can be considered employable. Your medical assessment and diagnosis of the individual's functional capacity is needed so the CAO can make a decision on the person's category of assistance and employability in the following manner:

1. **Capacity Unlimited** - the patient is determined to have no functional limitations, is not in need of health sustaining medication and is able to seek and maintain full-time gainful employment in a normal work environment with normal work schedules.

2. **Capacity Unlimited with Accommodations** - the patient is determined to be fully employable, provided that necessary accommodations are available to compensate for a physical or mental limitation and/or the need for health sustaining medication. Persons participating in a sheltered workshop program or supported employment more than 30 hours a week and requiring special accommodations to maintain employment may fit into this category.

   Physical Limitations are defined as physical impairments resulting from a significant non-correctable hearing or vision loss, mobility problems, or any physiological disorder that must be regulated by medication.

   Mental Limitations are defined as lack of touch with reality, anxiety or agitation under minor stress, depressed mood or social isolation due to emotional disturbances; inadequate responses to intellectual, emotional, social or physical demands due to limited intellectual capacity; or use of mind/mood altering drugs including alcohol.

   Health Sustaining Medication is defined as pharmaceutical maintenance needed to enable a person to seek and maintain full-time gainful employment in a normal work environment. This sub-block can be checked in conjunction with accommodations needed for physical/mental limitations or when no other accommodations are needed other than health sustaining medication.

   Physical or Mental Limitations or the need for health sustaining medication are indicated by a check-off in the appropriate block(s). Statements which substantiate and amplify the patient's physical/mental limitations and identify the health sustaining medication and type(s) of accommodations required are entered in the "Comments" section of the form.

3. **Capacity Limited** - the patient is determined to have functional limitations which prevent full-time employment, but allow part-time employment up to 30 hours weekly. Persons participating in a sheltered workshop program or in supported employment limited to working 30 hours a week or less may fit into this category.

   Physical Limitations - See above

   Mental Limitations - See above

   Health Sustaining Medication is defined as needing drug maintenance in order to seek and maintain part-time employment of up to 30 hours weekly.

   Physical or Mental Limitations - See above

4. **Temporarily Incapacitated** - the patient is determined temporarily unemployable due to a present incapacity or temporary symptomatic problem. Please indicate the expected duration of the temporary incapacity and whether a reassessment of the incapacity is needed after this date. Your statement in the "Comments" section will assist in substantiating why the patient is to be considered temporarily incapacitated for this period.

5. **Incapacitated** - the patient is determined unemployable, unable to maintain any formal employment. The severity of this incapacity should be reflected and amplified in the "Comments" section.

If block 2, 3, 4 or 5 is completed, the "Comments" section must be completed in terms that are comprehensible to a person not familiar with medical terms. (i.e., use terms such as cancer, diabetes, epilepsy, heart disease, psychosis, etc.). Prescription drugs which are prescribed from the P.D.R. categories or their generic equivalent as health sustaining medication, in connection with the primary or secondary diagnosis, must be identified. The information requested for persons who have received in patient care in a hospital or psychiatric unit for persons with mental illness/emotional disturbance or a public or private intermediate care facility for persons with mental retardation (ICF/MR) should be completed when the patient's record substantiates this information.

Sections IV. and V. Complete as indicated.

The medical provider's name, address and date of the client's last examination can be written, typed or stamped on the bottom of page 4. Signature of the physician or the physician or psychologist affiliated with a psychiatric clinic and date of signature is required.

RESET FIELDS

REPORT OF PHYSICAL/MENTAL EXAMINATION

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CTR DIG	DIST

RECORD NAME		LINE NO.
WORKER AND NUMBER	CASELOAD NO.	DATE

SECTION I COMPLETED BY CAO

NAME	MAIDEN NAME	BIRTHDATE (Mo./Day/Year)
ADDRESS	ZIP CODE	SOCIAL SECURITY NO.

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL/CLINICAL INFORMATION TO THE DEPARTMENT OF PUBLIC WELFARE AS NECESSARY TO DETERMINE MY ELIGIBILITY FOR ASSISTANCE.

SIGNATURE OF PUBLIC ASSISTANCE APPLICANT/RECIPIENT

DATE

**ARRANGE FOR AN APPOINTMENT WITH A PHYSICIAN OR LICENSED PSYCHIATRIC CLINIC.
MAIL OR RETURN THE FORM TO THE COUNTY ASSISTANCE OFFICE AS SOON AS POSSIBLE
ASK THE CAO WORKER FOR HELP TO SCHEDULE AN APPOINTMENT IF NECESSARY.**

SECTION II TO BE COMPLETED BY PHYSICIAN OR PSYCHOLOGIST

HISTORY (Complaints and history of present illness or dysfunction: (give date of onset))

DIAGNOSTIC STUDIES PREVIOUSLY PERFORMED: (Enter here the results of any special X-Ray, laboratory and other diagnostic studies relating to patient's present illness or disability - Give Dates.)

RETURN TO:

SECTION III (TO BE COMPLETED BY PHYSICIAN OR LICENSED PSYCHOLOGIST)

PLEASE CHECK EACH ITEM BELOW IN THE APPROPRIATE COLUMN AND DESCRIBE ABNORMALITIES AND DETAILED INFORMATION RELATED TO THE DISORDER.

PHYSICAL/MENTAL CAPACITY: CHECK (✓) THE MOST APPROPRIATE BLOCK IN THE LIST BELOW THAT REFLECTS YOUR OPINION OF THE PATIENT'S CAPACITY TO WORK.
(CHECK (✓) ONLY ONE)

1. ☐ **Capacity Unlimited.** Physical/Mental Capacity is adequate to seek and maintain full-time employment in a normal work environment with normal work schedules.

2. ☐ **Capacity Unlimited with Accommodations.** Handicapped or disadvantaged by a serious illness or condition, but not to the point that precludes full-time gainful employment if reasonable accommodations are made. Reasonable accommodations may include: structural modifications, modified work schedules, acquisition or modification of equipment or devices, provisions for readers or interpreters, job restructuring and other similar actions, or the need for drug maintenance.

   Check all of the blocks that apply:

   ☐ Physical Limitations ☐ Mental Limitations ☐ Health Sustaining Medication Needed

3. ☐ **Capacity Limited with Accommodations.** Has a chronic or acute physical or mental condition which restricts but does not prohibit employment if work is 30 hours or less a week.

   Check all of the blocks that apply:

   ☐ Physical Limitations ☐ Mental Limitations ☐ Health Sustaining Medication Needed

4. ☐ **Temporarily Incapacitated.** Currently incapacitated due to a temporary condition or as a result of an injury or an acute condition and the incapacity temporarily precludes employment.

   The temporary incapacity is expected to last until _____ (DATE).

   Is a reassessment of this condition needed after the above date? ☐ Yes ☐ No

5. ☐ **Incapacitated.** Limiting physical or mental condition which precludes employment.

COMMENTS: IF BLOCK 2, 3, 4 OR 5 IS CHECKED, SUBSTANTIATE YOUR ASSESSMENT OF PHYSICAL OR MENTAL INCAPACITY BY PROVIDING INFORMATION REGARDING:

(1) DIAGNOSIS (Primary and Secondary) AND MEDICATIONS RELATED TO EACH DIAGNOSIS.

Primary: Medications:

Primary: Medications:

(2) FUNCTIONAL LIMITATIONS

(3) HAS THE PATIENT EVER RECEIVED 30 CONTINUOUS DAYS OF INPATIENT CARE IN A HOSPITAL OR PSYCHIATRIC UNIT FOR THE MENTALLY ILL OR MENTALLY RETARDED?

☐ Yes ☐ No ☐ Unknown Length of time other than 30 days: _____

If Yes, please identify facility and date.

_____ (FACILITY) *FROM* _____ *TO* _____ (DATE)

(4) PERMANENT IMPAIRMENT OR MEDICAL CONDITION (DOES NOT REQUIRE REVERIFICATION)

SECTION IV GENERAL HEALTH INFORMATION

BLOOD PRESSURE	PULSE	HEIGHT	WEIGHT	DISTANT VISION	WITHOUT GLASSES		WITH GLASSES	
					RIGHT	LEFT	RIGHT	LEFT

HEARING	RIGHT	LEFT	BLOOD SEROLOGY	URINALYSIS	SP.GR.	ALBUMIN	SUGAR
Ordinary Conversation							

SECTION V CLINICAL FINDINGS (TO BE COMPLETED BY PHYSICIAN)

THE INFORMATION IN THIS SECTION WILL BE USED BY THE CAO TO MAKE AN ASSESSMENT OF YOUR PATIENT'S QUALIFICATION FOR (1) GENERAL ASSISTANCE OR (2) EXEMPTION FROM PUBLIC ASSISTANCE WORK REQUIREMENTS BECAUSE OF A PHYSICAL OR MENTAL CONDITION.

	Normal	Ab-normal	Not Evalu-ated	DETAILED INFORMATION
A. HEAD, NECK				
B. EYES AND EARS (General)				
C. NOSE, THROAT, MOUTH				
D. BREASTS				

E. PULMONARY DIAGNOSIS (if abnormal, please check (✓) appropriate diagnosis and provide detailed information which includes physical findings).

☐ BRONCHITIS ☐ BRONCHIAS ASTHMA
☐ BRONCHIECTASIS ☐ EMPHYSEMA
☐ PNEUMOCONIOSIS (Stage) ☐ PULMONARY FIBROSIS
☐ TUBERCULOSIS ☐ TUMOR
☐ OTHER

DETAILED INFORMATION SHOULD INCLUDE PERCUSSION, EFFECT OF EXERCISE, AUSCULATION, ETC.

F. CARDIOVASCULAR DISEASE (if abnormal, please provide diagnosis in blank space and include American Heart Association classification. Also check (✓) appropriate signs and symptoms block(s) and provide detailed information).

DIAGNOSIS:

☐ DYSPNEA: ☐ ON EXERTION ☐ AT REST
☐ CHECK PAINS: ☐ PERIPHERAL EDEMA (Site & Degree)
☐ LUNGS: (Rales, Emphysema, etc.) ☐ CYANOSIS: (Lips, Nails)
☐ HEART: ENLARGEMENT ☐ PULSE RATE: _____ Before exercise
☐ MURMURS: (Locate and describe) _____ After exercise
☐ PERIPHERAL VESSELS: (Describe) ☐ LIVER ENLARGEMENT: (Degree)
☐ CARDIAC CLASSIFICATION (AHA)

G. HEMIC (Sickle Cell, Anemia, Clotting Disorders, Leukemia)				
H. LYMPHATIC				
I. MULTIPLE BODY SYSTEM DISORDERS (Lupus, Morbid Obesity, etc.)				
J. IMMUNE DISORDERS (AIDS, etc.)				
K. NEOPLASTIC DISEASE (Cavier, etc.)				
L. SPECIAL SENSES & SPEECH DISORDERS				
M. ABDOMEN (palpitable abnormalities, hernia, scars, digestive disorders)				
N. RECTUM (Hemorrhoids, Prostate, Other)				
O. ENDOCRINE SYSTEM				
P. G-U SYSTEM				
Q. EXTREMITIES				

R. ORTHOPEDIC DISORDERS (Identify type of disorder and indicate range of motion, strength, ankylosis, muscle atrophy, etc.). If arthritis, specify type and check (✓) site of involvement.

☐ HIPS ☐ KNEES ☐ ANKLES
☐ TOES ☐ SHOULDERS ☐ ELBOWS
☐ WRISTS ☐ FINGERS ☐ SPINE

REMAINING FUNCTION: Describe patient's ability to do the following:

☐ WALK ☐ STAND ☐ KNEEL
☐ STOOP OR BEND ☐ LIFT ☐ CARRY

IS A BRACE OR PROSTHESIS WORN? ☐ YES ☐ NO
TYPE? _____ FOR HOW LONG? _____
HOW EFFECTIVE IS APPLIANCE?

S. SKIN				
T. PELVIC (Vaginal)				

U. NEUROLOGIC (If neurologic disease or abnormality is present, provide diagnosis and detailed information such as describe reflex changes, motor impairment, disturbance of gait, coordination, etc.)

IF EPILEPTIC, CHECK (✓) TYPE:
☐ GENERALIZED TONIC-CLONIC ☐ SIMPLE PARTIALS
☐ COMPLEX PARTIALS ☐ ABSENCE SEIZURES
IF SEIZURES ARE PRESENT, DESCRIBE SEIZURES AND INDICATE FREQUENCY.

SECTION V CLINICAL FINDINGS (CONTINUED)

	DETAILED INFORMATION
V. PSYCHIATRIC *DIAGNOSIS: (IF ABNORMAL, INDICATE DIAGNOSIS)* MENTAL OR EMOTIONAL DISTURBANCE (Please check (✓) appropriate abnormalities and provide detailed information.) ☐ A. ABNORMALITIES OF BEHAVIOR AND APPEARANCE. ☐ B. EVIDENCE OF POOR COMPREHENSION OR CONFUSION. ☐ C. ABNORMAL EMOTIONAL REACTION. ☐ D. ABNORMAL THOUGHTS OR IDEAS (Give descriptive quote) ☐ E. LEVEL OF MENTAL RETARDATION (Indicate IQ if known) ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND DO YOU CONSIDER THIS PERSON CAPABLE OF MANAGING HIS/HER OWN AFFAIRS? ☐ YES ☐ NO IS THIS PERSON ORIENTED FOR TIME? ☐ YES ☐ NO PLACE _____ OR PERSON _____ IS MEMORY DEFECT PRESENT FOR RECENT EVENTS? ☐ YES ☐ NO ☐ F. PSYCHOMOTOR	

SUMMARY AND EVALUATION: What is your general impression of the patient's attitude toward his/her condition? Is further study or specialist examination advisable for completeness of diagnosis, prognosis or treatment? If so, specify type and indicate specialist or institution of your choice.

I HEREBY CERTIFY THAT THE INFORMATION ABOVE IS BASED ON AN EXAMINATION OF THE PATIENT ON _____ (DATE) AND THAT IT IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

PHYSICIAN'S/PSYCHOLOGIST'S PRINTED NAME, ADDRESS & LICENSE NO.	PHYSICIAN'S/PSYCHOLOGIST'S SIGNATURE
	_____ (PREPARED) _____ (DATE) ☐ PHYSICIAN ☐ PSYCHOLOGIST