

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.

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 Evaluated	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). <input type="checkbox"/> BRONCHITIS <input type="checkbox"/> BRONCHIAS ASTHMA <input type="checkbox"/> BRONCHIECTASIS <input type="checkbox"/> EMPHYSEMA <input type="checkbox"/> PNEUMOCONIOSIS (Stage) <input type="checkbox"/> PULMONARY FIBROSIS <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> TUMOR <input type="checkbox"/> OTHER DETAILED INFORMATION SHOULD INCLUDE PERCUSSION, EFFECT OF EXERCISE, AUSCULTATION, 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). <i>DIAGNOSIS:</i> <input type="checkbox"/> DYSPNEA: <input type="checkbox"/> ON EXERTION <input type="checkbox"/> AT REST <input type="checkbox"/> CHECK PAINS: <input type="checkbox"/> PERIPHERAL EDEMA (Site & Degree) <input type="checkbox"/> LUNGS: (Rales, Emphysema, etc.) <input type="checkbox"/> CYANOSIS: (Lips, Nails) <input type="checkbox"/> HEART: ENLARGEMENT <input type="checkbox"/> PULSE RATE: _____ Before exercise <input type="checkbox"/> MURMURS: (Locate and describe) _____ After exercise <input type="checkbox"/> PERIPHERAL VESSELS: (Describe) <input type="checkbox"/> LIVER ENLARGEMENT: (Degree) <input type="checkbox"/> 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 (palpable 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. <input type="checkbox"/> HIPS <input type="checkbox"/> KNEES <input type="checkbox"/> ANKLES <input type="checkbox"/> TOES <input type="checkbox"/> SHOULDERS <input type="checkbox"/> ELBOWS <input type="checkbox"/> WRISTS <input type="checkbox"/> FINGERS <input type="checkbox"/> SPINE REMAINING FUNCTION: Describe patient's ability to do the following: <input type="checkbox"/> WALK <input type="checkbox"/> STAND <input type="checkbox"/> KNEEL <input type="checkbox"/> STOOP OR BEND <input type="checkbox"/> LIFT <input type="checkbox"/> CARRY IS A BRACE OR PROSTHESIS WORN? <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> GENERALIZED TONIC-CLONIC <input type="checkbox"/> SIMPLE PARTIALS <input type="checkbox"/> COMPLEX PARTIALS <input type="checkbox"/> 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