



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MEDICAL REPORT INCLUDING PHYSICIAN'S CERTIFICATION/DISABILITY EVALUATION

INDIVIDUAL NAME (FIRST)		(MIDDLE)	(LAST)		INDIVIDUAL 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:	
<p>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.</p> <p>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.</p>								
TO BE COMPLETED BY THE EXAMINING PHYSICIAN								
ARE YOU NOW OR HAVE YOU TREATED THIS PATIENT IN THE PAST YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE								
BRIEF CLINICAL HISTORY (CHIEF COMPLAINTS)								
HAS PATIENT BEEN HOSPITALIZED WITHIN THE PAST YEAR? <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO			DEGREE		MURMURS		RHYTHM	
EVIDENCE OF CARDIAC DECOMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO BASILAR RALES <input type="checkbox"/> YES <input type="checkbox"/> NO LIVER ENLARGEMENT <input type="checkbox"/> YES <input type="checkbox"/> NO PERIPHERAL EDEMA <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN.								
ANGINA PECTORIS? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN								
ABSENT PULSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN								
VARICOSITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN								
PULMONARY FUNCTION			RIGHT			LEFT		

NERVOUS SYSTEM			
PARALYSIS, SPEECH, GAIT, REFLEXES: PUPILLARY, KNEE, BABINSKI, ROMBERG			
EVIDENCE OF <input type="checkbox"/> PSYCHOSIS <input type="checkbox"/> NEUROSIS <input type="checkbox"/> MENTAL DEFICIENCY		DESCRIBE	
SEIZURES <input type="checkbox"/> NO <input type="checkbox"/> 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			
<input type="checkbox"/> SCARS	<input type="checkbox"/> TENDERNESS	<input type="checkbox"/> PALPABLY ENLARGED ORGANS	<input type="checkbox"/> HERNIA
DESCRIBE ITEMS CHECKED			
GENITO-URINARY			
<input type="checkbox"/> URETHRAL DISCHARGE	<input type="checkbox"/> HYDROCELE	<input type="checkbox"/> EPIDIDYMITIS	<input type="checkbox"/> PROSTATE <input type="checkbox"/> ABNORMAL TESTICAL
DESCRIBE ITEMS CHECKED			
GYNECOLOGICAL			
<input type="checkbox"/> PROLAPSE	<input type="checkbox"/> CYSTOCELE	<input type="checkbox"/> RECTOCELE	<input type="checkbox"/> CERVIX <input type="checkbox"/> ADNEXA <input type="checkbox"/> PREGNANT EXPECTED DUE DATE
DESCRIBE ITEMS CHECKED			
ANO-RECTAL			
<input type="checkbox"/> HEMORRHOIDS	<input type="checkbox"/> PROLAPSE	<input type="checkbox"/> FISSURES	<input type="checkbox"/> 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 FUNCTIONAL CAPACITY			
IS FURTHER DIAGNOSTIC EXAMINATION INDICATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE	
DETERMINATION OF INCAPACITY: In my opinion this individual (<input type="checkbox"/> does <input type="checkbox"/> 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:			
<input type="checkbox"/> 1 month <input type="checkbox"/> 3-5 months <input type="checkbox"/> 13 or more months <input type="checkbox"/> 2 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> 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

