**MEDICAL SUMMARY**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_ Claim Title (II/XVI): \_\_\_\_\_\_\_\_\_ DLI: \_\_\_\_\_\_\_\_\_

AOD: 00/00/0000 Date of Birth: Age at the time of AOD: Current Age:

Last Grade Completed: \_\_\_\_\_\_\_\_\_ Attended Special Ed Classes \_\_\_\_\_\_ ; (Ex\_\_\_).

**DATE PROVIDER REASON REF**

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