MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MEDICAL REPORT INCLUDING PHYSICIAN'S CERTIFICATION/DISABILITY EVALUATION

Individual Name (First)	(Middle Initial)	(Last)	Individual DCN	Date of Birth	Date Of App/Reapp/Review	Date Submitted to MRT

TO THE EXAMINING PHYSICIAN | Physician's Name: | Specialty:

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.

The Family Support Division has scheduled an appointment for _____(date/time) for _____ (what type of exam). You must return this completed form and appropriate records prior to payment being issued for this examination.

The Family Support Division **will not** assume responsibility for payment of inpatient costs unless **prior** written authorization is given by 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.

Reports may be completed by medical professionals within the scope of their licensed practice. This may include: licensed physicians (medical or osteopathic doctors); licensed or certified psychologists, including school psychologists; licensed optometrists; licensed podiatrists; qualified speech-language pathologists; licensed audiologists; licensed Advanced Practice Registered Nurse, or other licensed advanced practice nurse with another title; and licensed physician assistants.

To Be Completed by the Medical Professional Examining the Above Named Patient:

Are you now or have you treated this patient in the past year? ☐ Yes ☐ No If yes, date:

Brief clinical history (chief complaints)

Has patient been hospitalized within the past year?
☐ No ☐ Yes If yes, enter name of hospital

Hospital

Complete for patient		Blood Pressure		HGB or HCT, if indicated		Urinalysis	
Weight	Height	Systolic	Diastolic	HGB	HCT	Sugar	Albumen

Eyes – Vision:		Best Corrected Vision:		**Ears** Hearing (Ordinary Conversation)	
Right	Left	Right	Left	Right (20 Ft.)	Left (20 Ft.)

Nose, Throat, Mouth, Neck (Abnormalities)

Cardiovascular System

Cardiac Enlargement? ☐ Yes ☐ No	Degree	Murmurs	Rhythm

Evidence Of Cardiac Decompensation ☐ Yes ☐ No Basilar Rales ☐ Yes ☐ No
Liver Enlargement ☐ Yes ☐ No Peripheral Edema ☐ Yes ☐ No If Yes, Please Explain.

Angina Pectoris? ☐ Yes ☐ 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? ☐ Yes ☐ No If Yes, Explain

Absent Pulsation? ☐ Yes ☐ No If Yes, Explain

Varicosities? ☐ Yes ☐ No If Yes, Explain

Pulmonary Function	Right	Left

Individual Name (First)	(Middle)	(Last)	Individual DCN	Date Of Birth

Nervous System

Paralysis, Speech, Gait, Reflexes: Pupillary, Knee, Babinski, Romberg

Mental Disorder: Include any current and past DSM diagnosis, and most current mental status examination. Also, note if no mental disorders are indicated.

Seizures ☐ No ☐ Yes If Yes, List ►	Type	Frequency of attacks with medication

Neoplasms

Site	☐ Malignant ☐ Benign	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

☐ Scars	☐ Tenderness	☐ Palpably Enlarged Organs	☐ Hernia

Describe items checked

Genito-Urinary

☐ Urethral Discharge	☐ Hydrocele	☐ Epididymitis	☐ Prostate	☐ Abnormal Testicle

Describe items checked

Gynecological

☐ Prolapse	☐ Cystocele	☐ Rectocele	☐ Cervix	☐ Adnexa	☐ Pregnant	Expected Due Date

Describe items checked

Ano-Rectal

☐ Hemorrhoids	☐ Prolapse	☐ Fissures	☐ Fistula

Describe items checked

Other laboratory findings (attach written report of x-rays, EKG, or other laboratory findings)

Diagnosis

Primary:

Secondary:

Known Medications:

Summarize findings with emphasis on functional capacity:

Is Further Diagnostic Examination Indicated? ☐ Yes ☐ No	Type

Determination of Incapacity: In my opinion this individual (☐ does ☐ 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:

☐ 1 month	☐ 2 months	☐ 3-5 months	☐ 6-12 months	☐ 13 months or longer	☐ Permanent

The above findings and statements are based on my examination and/or records.

Signature	**Date**
Print Name	**Phone Number**