MEDICAL EXAMINATION REPORT

Michigan Department of Human Services

Case Name:
Case Number:
Date:
DHS Office:
Specialist / ID: /
Phone:
Fax:
Individual ID:

If you do not understand this, call a DHS office in your area.
DHS employees are prohibited by law from providing legal advice.
Si Ud. no entiende esto, llame a su oficina local del Department of Human Services.
La ley prohíbe a los empleados de DHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فأتصل بمكتب DHS الموجود في منطقتك.
يحرّم القانون على موظفي DHS إعطاء النصيحة القانونية.

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: P.A. 288 of 1988, P.A. 368 of 1996, or 42 CFR and 45 CFR.
COMPLETION: Voluntary.

SPECIALIST INSTRUCTIONS: Complete identifying client information. **Attach DHS-1555**, Authorization To Release Medical Information and a self-addressed stamped envelope.

CLIENT INFORMATION

Client Name	Date of Birth	Gender ☐ Male ☐ Female

➔ ***(DHS SPECIALIST, PLEASE COMPLETE No. 1)***

1. Applicant reports the following disabling conditions:

➔ ***PHYSICIAN INSTRUCTIONS: Please fill out the following and/or send a copy of treatment notes for the last 12 months.***

2. Date you **first** examined patient?	3. Date of **last** examination:

3. CURRENT DIAGNOSES AND CHIEF COMPLAINT(S)

4. CURRENT MEDICATIONS:

5. PHYSICAL EXAMINATION:

EXAM FINDINGS	Height	**Current Weight**	Blood Pressure /	Dominant Hand ☐ R ☐ L	**Visual Acuity (best corrected)** 20/ OD 20/ OS

EXAMINATION AREAS By Body System		**REPORT FINDINGS IN DETAIL in this section and COMMENT ON ETIOLOGY OF FINDINGS OR REPORT/PROVIDE OBJECTIVE STUDIES and EVIDENCE that SUPPORT those FINDINGS**
GENERAL:	*(general appearance, ability to move about, dress & undress, stance, fatigue, pain level, alert, etc.)*	
HEENT:	*(cataracts, PERRLA, fundi, ptosis, glaucoma, perforated drums, discharge, deafness, blindness, infections)*	If vision is affected, what is the best corrected visual acuity?
RESPIRATORY:	*(wheezing, rales, rhonchi, SOB, accessory muscles used, sleep apnea, cyanosis, crackles, etc.)*	
CARDIO-VASCULAR:	*(chest pain, ejection fraction, enlargement, murmurs, rhythm, dyspnea, cyanosis, edema, palpitations, DVT, PVD, JVD, claudication, diminished pulses)*	
ABDOMINAL:	*(organ enlargement, tenderness, masses, ascites, liver function, scars-history of surgery, CVA tenderness)*	

MUSCULO-SKELETAL:	*(description of gait, SLR findings – if positive at what degrees and location of pain, ROM in degrees, DTR equal or asymmetric, status of musculature, atrophy, weakness, etc.) Is grip strength impaired? Can they write, button clothes, open jar, etc.*	Check this box ☐ if an ambulatory aid is medically required. Please describe what kind and why?
NEURO:	*Is there any evidence of a neurologic disorder? _____, or neurologic deficit as a result of a back impairment _____? (motor, sensory, seizures, speech, reflexes, ataxia, coordination, paralysis, tremors)*	
MENTAL:	*(affect, mood, comprehension, alert and oriented, ability to follow directions, memory, etc.)*	

6. LABORATORY AND X-RAY FINDINGS:
(Please attach pertinent lab reports, EKGs, GXT, catherization results, Echocardiogram, x-ray, CT scan and MRI reports)

7. CLINICAL IMPRESSIONS:

☐ IMPROVING ☐ STABLE ☐ DETERIORATING

8. PHYSICAL LIMITATIONS

☐ NO LIMITATIONS
☐ LIMITED (Indicate on charts below)

Is this limitation expected to last more than 90 days?

☐ YES ☐ NO

A. Lifting/Carrying

	FREQUENTLY (2/3 of 8 hr. day)	OCCASIONALLY (1/3 of 8 hr. day)	NEVER
Less than 10 lbs.	☐	☐	☐
10 lbs.	☐	☐	☐
20 lbs.	☐	☐	☐
25 lbs.	☐	☐	☐
50 lbs. or more	☐	☐	☐

B. Standard/Walking and Sitting

Stand and/or walk less than 2 hours in an 8-hour workday	☐
Stand and/or walk at least 2 hours in an 8-hour workday	☐
Stand and/or walk about 6 hours in an 8-hour workday	
Sit less than 6 hours in an 8-hour workday	☐
Sit about 6 hours in an 8-hour workday	☐

C. Are Assistive Devices medically required and needed for ambulation?

☐ NO ☐ YES (If YES, describe below)

The individual should be able to use his/her extremities for REPETITIVE ACTION such as:

HANDS/ARMS:	NEITHER	BOTH	LEFT	RIGHT
• Simple grasping	☐	☐	☐	☐
• Reaching	☐	☐	☐	☐
• Pushing/Pulling	☐	☐	☐	☐
• Fine Manipulating	☐	☐	☐	☐

FEET/LEGS:	NEITHER	BOTH	LEFT	RIGHT
• Operating Food/Leg Controls:	☐	☐	☐	☐

What are the medical findings that support the above physical limitations?

_____

_____

9. MENTAL LIMITATIONS (Check appropriate box) ☐ NO LIMITATIONS ☐ LIMITED IN THE FOLLOWING (Check appropriate box(es))

☐ Comprehension ☐ Sustained Concentration ☐ Reading Writing
☐ Memory ☐ Following simple directions ☐ Social Interaction

What are the findings that support the above mental limitations?

_____

_____

10. Can the client meet his/her needs in the home?

☐ YES ☐ NO If NO, what assistance is needed?

☐ Functional information completed by the physician with supportive medical findings
☐ Functional information strictly from the patient and not based on medical findings

11. Signature of Physician	12. Printed Name of Physician	13. Physician's Specialty
14. Address	15. Telephone Number ( )	16. Date Form Completed