MONROE COUNTY DEPARTMENT OF HUMAN SERVICES

PHYSICAL ASSESSMENT FOR DETERMINATION OF EMPLOYABILITY (ALL SECTIONS MUST BE COMPLETED)

PLEASE RETURN MEDICAL STATEMENT TO:

Attn: Team: Worker: Phone: Fax: Phone: Fax: Phone: Fax: Phone: Fax: Phone: Fax: Phone: Phone: Phone: Pax: Phone: P		roe County Department of Human Services 691 St. Paul Street ochester, NY 14605	111 Westfall Road Rochester, NY 1462	0	
DATE OF EVALUATION:	Attn	: m: Worker:	·		_ Fax:
CLIENT IDENTIFICATION: NAME: DHS CASE#: DHS CASE#: DHS CASE#: DHS CASE#: Street City State Zip S\$# (last 4 digits): CIN: DOB: State Zip S\$# (last 4 digits): DOB: DOB: State City State	Due	to MCDHS worker by(date)			
NAME: DHS CASE#: ADDRESS: Street	DAT	E OF EVALUATION:	PROVI	DER:	
ADDRESS: Street	<u>CLI</u>	ENT IDENTIFICATION:			
Street City State Zip SS# (last 4 digits):					
Is the Client a Veteran	ADL		City	State	Zip
Does client have an active SSI/SSD application pending?	SS#	(last 4 digits):	CIN:	DOB:_	
Date client became a patient at your practice:	Is th	e Client a Veteran 🔲 🖂 Yes 🔲 🗆 No			
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION I authorize the examining physician/provider to disclose to the Department of Human Services any information provided, and diagnoses made, conditions revealed, and functional limitations identified, as a result of the examination given. I understand that the information provided by this authorization may be re-disclosed by the recipient of this information and will no longer be protected by the Health Insurance Portability and Accountability Act as protected health information. However, the information will only be released pursuant to the New York State Social Services Law, the New York State Public Health Law and other applicable federal and state laws and regulations. I understand that this information will be treated as confidential. Signature:	Doe	s client have an active SSI/SSD application pe	ending? □□ Yes	□□ No	
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION I authorize the examining physician/provider to disclose to the Department of Human Services any information provided, and diagnoses made, conditions revealed, and functional limitations identified, as a result of the examination given. I understand that the information provided by this authorization may be re-disclosed by the recipient of this information and will no longer be protected by the Health Insurance Portability and Accountability Act as protected health information. However, the information will only be released pursuant to the New York State Social Services Law, the New York State Public Health Law and other applicable federal and state laws and regulations. I understand that this information will be treated as confidential. Signature: Date: Witness: Date: EMPLOYABILITY: Providers, Please complete fully, the section that applies to your patient. Indicate which of the following four statements best describes the individual's condition and elaborate, if indicated. Please note that the responsibility for determining employability related to substance abuse is determined solely by the District's Certified Alcohol and substance Abuse Counselor (CASAC). If completing Sections 2-4, complete rest of form. CAN CLIENT USE PUBLIC TRANSPORTATION: Individual is able to participate in activities (e.g. work, education and training) for up to 40 hours per week, does	Date	e client became a patient at your practice:	[Date of Last Examination	on:
I authorize the examining physician/provider to disclose to the Department of Human Services any information provided, and diagnoses made, conditions revealed, and functional limitations identified, as a result of the examination given. I understand that the information provided by this authorization may be re-disclosed by the recipient of this information and will no longer be protected by the Health Insurance Portability and Accountability Act as protected health information. However, the information will only be released pursuant to the New York State Social Services Law, the New York State Public Health Law and other applicable federal and state laws and regulations. I understand that this information will be treated as confidential. Signature: Date: Date: EMPLOYABILITY: Providers, Please complete fully, the section that applies to your patient. Indicate which of the following four statements best describes the individual's condition and elaborate, if indicated. Please note that the responsibility for determining employability related to substance abuse is determined solely by the District's Certified Alcohol and substance Abuse Counselor (CASAC). If completing Sections 2-4, complete rest of form. CAN CLIENT USE PUBLIC TRANSPORTATION: Yes No	How	many times have you evaluated the above pa	atient in the last 12 mor	nths:_	
Witness:	I aut mad provi Insui the N	horize the examining physician/provider to disclose e, conditions revealed, and functional limitations ide ided by this authorization may be re-disclosed by the rance Portability and Accountability Act as protected lew York State Social Services Law, the New York	to the Department of Hui entified, as a result of the e recipient of this informat d health information. How State Public Health Law	examination given. I und ation and will no longer be vever, the information wil	derstand that the information e protected by the Health I only be released pursuant to
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	Ind	licate which of the following four statements be use note that the responsibility for determining or rict's Certified Alcohol and substance Abuse Co	est describes the indivi- employability related to ounselor (CASAC). <u>If</u>	dual's condition and electric substance abuse is described completing Sections 2	aborate, if indicated. letermined solely by the -4, complete rest of form.
I DOI DAVE ADVINITATIONS AND DOSSING TOURS AND TRADITION AND AND AND AND AND AND AND AND AND AN	1.				

E	xpected Duration: weeks, months, year(s)
	easonable Accommodations: Describe any reasonable accommodations which are recommended based or lentified disabilities:
_ D	escribe any working conditions, environments or work activities which are contraindicated:
	pecify treatment, diagnosis and/or referral recommendations, including referral to the District's CASAC for ubstance abuse assessment:
S	Individual is unable to participate in activities except treatment or rehabilitation (specify treatment/rehabilitation (specify treatment/rehabilitation). Expected Duration: weeks, months pecify treatment, diagnosis and/or referral recommendations, including referral to the istrict's CASAC for substance abuse sessment:
R	eason: If less than 40 hours, list reason(s) individual is unable to participate in full time activities:
aı	Individual appears permanently disabled, condition is not expected to improve and is unable to participate in ny activities. SI Referral is based on:

(B) N	MEDICAL	CONDITIONS -	 Please 	list all	past medical	conditions:
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	Diag	jnosis		Treat	ment			Prognosis
	<u> </u>		l					
)	HOSPITALIZATIONS	- Please I	ist all past m	nedical conditi	ons in order	of priority:		
Date Diagnosis		ınosis	Treatment		Prognosis			
١.	CURRENT MEDICAT	TIONS						
		TONS	Ma	li ti		Da		F
<u> </u>	ate 1st Prescribed		ivied	dication		Do	sage	Frequency
IST	THE SIDE EFFECTS	S CLIENT E	EXPERIENC	ES WITH ME	EDICATION,	F ANY: _		
IST	THE SIDE EFFECTS	S CLIENT E	EXPERIENC	ES WITH ME	EDICATION,	F ANY: _		
IST	THE SIDE EFFECTS	S CLIENT E	EXPERIENC	ES WITH ME	EDICATION,	F ANY: _		
	THE SIDE EFFECTS							
Ξ) Ι	PHYSICAL EXAMINA	ATION – Lis	st physical ex	xam findings	and/or evider	nce that su	pports the d	iagnosis(es):
E) I	PHYSICAL EXAMINA	ATION – Lis	st physical ex	xam findings V	and/or evider	nce that su	pports the d	iagnosis(es):
E) I	PHYSICAL EXAMINA tht without shoes: d Pressure:	ATION – Lis	st physical ex	xam findings V	and/or evider	nce that su	pports the d	iagnosis(es):
eig loo	PHYSICAL EXAMINATION of the without shoes: d Pressure: piration:	ATION – Lis	st physical ex	xam findings V	and/or evider Veight withou	nce that su	pports the d	iagnosis(es):
E) I	PHYSICAL EXAMINA tht without shoes: d Pressure:	ATION – Lis	st physical ex	xam findings V	and/or evider Veight withou	nce that su	pports the d	iagnosis(es):
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leig loodesk	PHYSICAL EXAMINATION of the without shoes: d Pressure: priration: on (if applicable): Rig System General Appearance	ATION – Lis	Left 20/	xam findings V Abnormal	and/or evider Veight withou Pulse: oth 20/	t shoes:	n Chart at 20	iagnosis(es): iegnosis(es): iegnosis(es):
E) I	PHYSICAL EXAMINATION of the without shoes: In the without shoes: System	ATION – Lis	st physical example. Left 20/	xam findings V L Abnormal	and/or evider Veight withou Pulse: oth 20/	t shoes:	n Chart at 20	iagnosis(es): iegnosis(es): iegnosis(es):

					I/EDR:10
Е	Skin				
F	Lymph Nodes				
G	Head & Face				
Н	Eyes				
I	Ears, Nose, Throat				
J	Neck				
K	Respiratory				
L	Heart				
M	Abdomen				
N	Musculoskeletal				
0	Neurological				
Р	Extremities				
Q	Hands				
(F)	ESTIMATED FUNCTIONA	AL LIMITATIONS I	N AN 8 HO	UR WORK DAY	
	FUNCTIONING	NO EVIDENC	°E OE	MODERATELY LIMITED	VEDVIIMITED
	FUNCTIONING	NO EVIDENO LIMITATIO		MODERATELY LIMITED	VERY LIMITED
	lking		ONS	MODERATELY LIMITED 2-4 Hours	VERY LIMITED 1-2 Hours
Sta	lking nding	LIMITATIC	ONS ours \square		
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Sta Sitt	Iking nding ing shing, Pulling, Bending	LIMITATION More than 4 He More than 4 He	ours ours ours ours	2-4 Hours 2-4 Hours	1-2 Hours 1-2 Hours
Sta Sitt Pus See	Iking nding ing shing, Pulling, Bending eing, Hearing, Speaking	More than 4 Ho More than 4 Ho More than 4 Ho	ours	2-4 Hours 2-4 Hours 2-4 Hours	1-2 Hours 1-2 Hours 1-2 Hours
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Sta Sitt Pus See Abi	Iking nding ing shing, Pulling, Bending eing, Hearing, Speaking lity to lift/carry DICAL PROFESSIONAL'S chologist, Physicians' Assistant	More than 4 Ho More than 5 Hore than 1 Hore More than 6 Hore than 1 Hore More than 6 Hore than 1 Hore More than 1 Hore	ours	2-4 Hours	1-2 Hours 1-2 Hours
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