

County _____
Case Name _____
Case No. _____

REPORT OF MEDICAL EXAMINATION
(Complete entire report)

TANF PROGRAM **TANF WORK PROGRAM**
 Initial Report **Initial Report**
 Review Report **Review Report** **Date of Last Report** _____

Patient Name: _____ **SSN:** _____ - _____ - _____
(Last) (First) (Middle)
Age _____ **DOB** _____ **Race** _____ **Sex** _____

Address: _____
(Home: Street & Number) (City) (State) (Zip Code)

Is Patient Medicaid Eligible? **YES** **NO**

The requested Medical information will be used to determine this person's eligibility for TANF cash assistance, work capability in the TANF Work Program and/or eligibility for Vocational Rehabilitation services, if applicable.

HISTORY

CHIEF COMPLAINT AND PRESENT ILLNESS: _____

History of debilitating diseases, operations, communicable diseases, medications and complications if any: _____

REVIEW OF SYSTEMS: List only positive symptoms. For example, if Cardiovascular system is involved, indicate degree of Cyanosis, Dyspnea and Edema (example - Edema 4+)

PHYSICAL EXAMINATION (REQUIRED): Height _____ ft. _____ in. Weight _____
Temperature _____ Pulse _____ Respiration _____ Blood Pressure _____

(List Abnormalities Only.) Please list all relevant abnormal physical findings and/or note if the body system is normal.

H.E.E.N.T _____
CARDIOVASCULAR _____
RESPIRATORY _____
GI _____
GU _____
ORTHOPEDIC IMPAIRMENT _____
GENITALIA _____
HERNIA _____
NEUROLOGIC AND MENTAL STATUS _____

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URINALYSIS:

SPECIFIC GRAVITY _____

ALBUMIN _____

SUGAR _____

Other pertinent laboratory data: _____

CASTS _____

BLOOD _____

PUS _____

Physical Capacities: (Use symbols as follows: (√) No limitation (X) Limitations (O) to be avoided.)

Physical activities: Walking____ Standing____ Stooping____ Kneeling____ Lifting____ Reaching____
Pushing____ Pulling____ Other (specify)_____

Working conditions: Outside____ Inside____ Humid____ Dry____ Dusty____
Sudden temperature changes____ Other (specify)_____

Please specify if limits exist _____

DIAGNOSIS AND SEVERITY

TREATMENT

If eligible for Medicaid, is this person assigned to you as their primary care provider? YES NO

If this is a review report, has individual followed previous recommended treatment and procedures? YES NO

Please Explain _____

Has there been improvement since last report? YES NO

Please specify _____

Is individual under treatment now? YES NO By whom? _____

If under treatment now, list specific therapy, length of therapy and effect. _____

If not under treatment now, what do you recommend? _____

Is examination or treatment by a specialist indicated? YES NO

If yes, please specify _____

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PROGNOSIS AND EFFECT ON ABILITY TO WORK

Effect illness or disability will have on the individual's ability to work, including restrictions _____

Do you consider the individual able to perform work activities for 6 to 8 hours per day? YES NO

If yes, list any recommended work restrictions, such as hours standing/working, pounds to lift/carry, etc. the individual **can** perform. _____

What medical limitations does the individual have? _____

Are these limitations: Short term Long term How Long? _____

Do you feel the individual is able to participate in education and/or training activities at this time? YES NO
If no, why not _____

REMARKS: Please elaborate: _____

Date: _____

Examining Physician's Signature: _____

Examining Physician's Title (check one): M.D., D.O., PHD, FNP or Therapist

Name (please print): _____

Complete Mailing Address: _____