MONROE COUNTY DEPARTMENT OF HUMAN SERVICES

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

PLEASE RETURN MEDICAL STATEMENT TO:

Monroe County Department of Human Services
☐ 691 St. Paul Street
Rochester, NY 14605

☐ 111 Westfall Road
Rochester, NY 14620

Attn:
Team:_____ Worker:_____ Phone:_____ Fax:_____
(Please Print)

Due to MCDHS worker by_____
(date)

DATE OF EVALUATION:_____ PROVIDER:_____

CLIENT IDENTIFICATION:

NAME:_ _____ DHS CASE#:_ _____

ADDRESS:__ _____ __ _____ _____ __
Street City State Zip

SS# (last 4 digits):___ _____ CIN:__ _____ DOB:_ _____

Is the Client a Veteran ☐ Yes ☐ No

Does client have an active SSI/SSD application pending? ☐ Yes ☐ No

Date client became a patient at your practice:__ _____ Date of Last Examination:_ _____

How many times have you evaluated the above patient in the last 12 months:_ _____

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: ☐ Yes ☐ No

1.	☐ Individual is able to participate in activities (e.g. work, education and training) for up to 40 hours per week, does not have any limitations and does not require any treatment/rehabilitation or assessment by the district's CASAC

2. ☐ Individual is able to participate in activities (e.g. work, education and training).

☐ for up to 40 hours **with reasonable accommodations** -- OR --
☐ _____ hours per week **with reasonable accommodations**

If less than 40 hours, list reason(s) individual is unable to participate in full time activities:

_____

Expected Duration:_____ weeks, months, year(s)

Reasonable Accommodations: Describe any reasonable accommodations which are recommended based on identified disabilities:

_____

_____

Describe any working conditions, environments or work activities which are contraindicated:

_____

_____

_____

Specify treatment, diagnosis and/or referral recommendations, including referral to the District's CASAC for substance abuse assessment: _____

_____

3. ☐ Individual is unable to participate in activities except treatment or rehabilitation (specify treatment/rehabilitation).

Expected Duration:_____ weeks, months

Specify treatment, diagnosis and/or referral recommendations, including referral to the District's CASAC for substance abuse

asessment:_____

_____

_____

Reason: **If less than 40 hours, list reason(s) individual is unable to participate in full time activities:**

_____

_____

4. ☐ Individual appears permanently disabled, condition is not expected to improve and is unable to participate in any activities.

SSI Referral is based on:_____

_____

_____

Specify if referral to the District's CASAC for substance abuse assessment is recommended: ☐ Yes ☐ No

(A) **CHIEF COMPLAINT(S)/HISTORY OF PRESENT ILLNESS:**

_____

_____

_____

_____

(B) **MEDICAL CONDITIONS –** Please list all past medical conditions:

Date	Diagnosis	Treatment	Prognosis

(C) **HOSPITALIZATIONS –** Please list all past medical conditions in order of priority:

Date	Diagnosis	Treatment	Prognosis

(D) **CURRENT MEDICATIONS**

Date 1st Prescribed	Medication	Dosage	Frequency

LIST THE SIDE EFFECTS CLIENT EXPERIENCES WITH MEDICATION, IF ANY: _____

_____

(E) **PHYSICAL EXAMINATION –** List physical exam findings and/or evidence that supports the diagnosis(es):

Height without shoes:_____' _____" Weight without shoes: _____

Blood Pressure: _____/_____ Pulse: _____

Respiration: _____

Vision (if applicable): Right 20/_____ Left 20/_____ Both 20/_____ Snellen Chart at 20 feet

	System	Normal	Abnormal	Details *(if abnormal).* If being seen/seen by a Specialist, please give physician's full name if known
A	**General Appearance**	☐	☐	
B	**Gait**	☐	☐	
C	**Heel & Toe Walking**	☐	☐	
D	**Squat**	☐	☐	

E	**Skin**	☐	☐	
F	**Lymph Nodes**	☐	☐	
G	**Head & Face**	☐	☐	
H	**Eyes**	☐	☐	
I	**Ears, Nose, Throat**	☐	☐	
J	**Neck**	☐	☐	
K	**Respiratory**	☐	☐	
L	**Heart**	☐	☐	
M	**Abdomen**	☐	☐	
N	**Musculoskeletal**	☐	☐	
O	**Neurological**	☐	☐	
P	**Extremities**	☐	☐	
Q	**Hands**	☐	☐	

(F) **ESTIMATED FUNCTIONAL LIMITATIONS IN AN 8 HOUR WORK DAY**

FUNCTIONING	NO EVIDENCE OF LIMITATIONS	MODERATELY LIMITED	VERY LIMITED
Walking	More than 4 Hours ☐	2-4 Hours ☐	1-2 Hours ☐
Standing	More than 4 Hours ☐	2-4 Hours ☐	1-2 Hours ☐
Sitting	More than 4 Hours ☐	2-4 Hours ☐	1-2 Hours ☐
Pushing, Pulling, Bending	More than 4 Hours ☐	2-4 Hours ☐	1-2 Hours ☐
Seeing, Hearing, Speaking	More than 4 Hours ☐	2-4 Hours ☐	1-2 Hours ☐
Ability to lift/carry	More than 4 Hours ☐	2-4 Hours ☐	1-2 Hours ☐

MEDICAL PROFESSIONAL'S INFORMATION: Form must be completed & signed by a Physician, Psychiatrist, Psychologist, Physicians' Assistant or Nurse Practitioner.

Name:_____
(Please Print)

Address:_____

Board Eligible or Certified Specialty:_____

Signature:_____

Phone:_____

Date form completed:_____