Ohio Department of Medicaid

BASIC MEDICAL

Section 1 – Individual Identifying Information To Be Completed By Caseworker					
Case Number	Medicaid ID	Social Security Number		Date of Birth	Sex ☐ Female ☐ Male
Last Name		First Name			M.I.
Address	City	State	Zip Code		Phone

Section 2 – County Agency Identifying Information To Be Completed By Caseworker			
County Agency Name	Caseworker Name	Caseload ID	Caseworker/Agency Phone
County Agency Address	City	State	Zip Code

Section 3 – Individual Medical Information To Be Completed By Physician

Please send copies of all relevant information supporting the medical conditions, including reports of x-rays, scans, laboratory tests, consultant reports, hospital discharge summaries, etc.

Date of Last Examination:

A. Physical Examination/Vital Signs

Height:	Weight:	Pulse Rate:	Blood Pressure:	Respiratory Rate:

HEENT:	Abdomen:
Chest:	Heart:
Extremities:	Neurological:

Visual Acuity:	OS:	OD:
ROM:	Spine:	Joints:

B. Pregnancy Verification Only.

Date of Test:	Expected Date of Delivery:

C. Describe the Individual's Medical Conditions (Physical and Mental). Include ICD-10 Diagnosis and/or DSM-IV Codes

D. History of Medical Conditions (Onset, Duration, Treatment, Prescribed Medications, Prognosis, etc.)

E. Health Status

☐ Improving ☐ Improving without Tx ☐ Improving with Tx ☐ Good/Stable with Tx ☐ Poor but Stable ☐ Deteriorating

F. Physical/Psychological/Psychiatric Findings
Also Complete Section G and/or ODM 07308 for Mental Impairments as Appropriate.

Last Name	First Name	M.I.	Medicaid ID	Social Security Number

G. Are Additional Studies or Treatment Indicated? If Yes, Specify

H. Physical Functional Capacity Assessment

Considering the combined effects of the medical conditions noted on page 1, please answer the following:

1. Are standing/walking affected? ☐ Yes ☐ No

   If yes, how many hours in an 8-hour workday can the individual stand/walk? _____

   How many hours without interruption? _____

2. Is sitting affected? ☐ Yes ☐ No

   If yes, how many hours in an 8-hour workday can the individual sit? _____

   How many hours without interruption? _____

3. Are lifting/carrying affected? ☐ Yes ☐ No

If yes, up to how many pounds can the individual lift/carry frequently? (up to 2/3 of the workday)

☐ Up to 5 pounds ☐ 6-10 pounds ☐ 11-20 pounds ☐ 21-25 pounds ☐ 26-50 pounds ☐ 51-100 pounds

If yes, up to how many pounds can the individual lift/carry occasionally? (up to 1/3 of the workday)

☐ Up to 5 pounds ☐ 6-10 pounds ☐ 11-20 pounds ☐ 21-25 pounds ☐ 26-50 pounds ☐ 51-100 pounds

4. Are the following functions affected? If so, how?	None	Not Significantly Limited	Moderately Limited	Markedly Limited	Extremely Limited
Pushing/Pulling	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Handling	☐	☐	☐	☐	☐
Repetitive Foot Movements	☐	☐	☐	☐	☐
Seeing	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐

5. What observations and/or medical evidence led to your findings in questions H1 – H4? Please provide examples of specific physical limitations:

After taking the appropriate history and performing the relevant physical examination, do you believe the individual is:

☐ Employable ☐ Unemployable

How long are the physical and/or mental functional limitations listed above expected to last?

☐ Less than 30 days ☐ Between 30 days and 9 months ☐ Between 9 months and 11 months ☐ 12 months or more

Will disclosure of this information to the individual have an adverse effect? ☐ Yes ☐ No

Physician's Signature	Physician's Name *(Please print)*		
Specialty	Physician's Phone		
Address	City	State	Zip Code