MEDICAL EXAMINATION FOR ABAWD DETERMINATION

Please forward this completed form to Social Services Contact: **CED ABAWD Team**

Fax #: **858-1065** Address: **290 Main St 10th Floor Buffalo NY 14202**

All changes in medical status affecting employability must be reported and documented timely.

I. CLIENT IDENTIFICATION

Print Client Name: ______________________________ Veteran: ☐ Yes ☐ No

Address: ______________________________

Case #: ____________ CIN: ____________ DOB: ____________

Reason(s) for referral: Client states that: ______________________________

____

II. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the examining health care practitioner to disclose to the Department of Social Services any information provided, any diagnoses made, conditions revealed, functional limitations and any prognoses identified, as a result of the examination given. I understand that this information will be treated as confidential.

Client Signature **x**______________________________Date: ____________

AUTORIZACIÓN DE REVELACIÓN DE DATOS MÉDICOS

Autorizo al médico examinador a revelar al Departamento de Servicios Sociales todo dato relativo a diagnósticos, aflicciones médicas, limitaciones funcionales y todo prognosis detectado como resultado del examen realizado. Entiendo que estos datos son de carácter confidencial.

Firma del Cliente **x**______________________________Fecha: ____________

III. MEDICAL INFORMATION

List all medical conditions. Include psychiatric and alcohol/drug addiction diagnosis using DSM-IV format. (List all medical diagnoses and specify medical/clinical findings, including prognoses.)

Medical Condition	**Prognosis and Treatment Recommendations including prescribed medications**	**Date of original diagnosis/diagnosis type**
		Date: ❑ Physical Health ❑ Mental Health ❑ Substance Use Disorder ❑ Other
		Date: ❑ Physical Health ❑ Mental Health ❑ Substance Use Disorder ❑ Other
		Date: ❑ Physical Health ❑ Mental Health ❑ Substance Use Disorder ❑ Other
		Date: ❑ Physical Health ❑ Mental Health ❑ Substance Use Disorder ❑ Other

IV. FUNCTIONAL LIMITATIONS (related to medical findings noted in Section III): *(check column that applies)*

a.) Physical Functioning	No Evidence of Limitations	Moderately Limited	Very Limited	b.) Mental Functioning	No Evidence of Limitations	Moderately Limited	Very Limited
Walking				Understands and remembers instructions			
Standing				Carries out instructions			
Sitting				Maintains attention/concentration			
Lifting, Carrying				Makes simple decisions			
Pushing, Pulling, Bending				Interacts appropriately with others			
Seeing, Hearing, Speaking				Maintains socially appropriate behavior without exhibiting behavior extremes			
Using Hands				Maintains basic standards of personal hygiene and grooming			
Stairs or other climbing				Appears able to function in a work setting at a consistent pace			
Other:				Other:			

V. TREATMENT HISTORY (list for medical, and/or psychiatric treatment for the past Two Years)

Name of Program/Provider	Type of Program/Provider	Length of Treatment (# of Months)

VI. CURRENT TREATMENT PROGRAM IDENTIFICATION

Program Name: ______________________________

Address of Client's Treatment Site: ______________________________

Mailing Address (If different from above): ______________________________

Treatment Program Contact: ______________________ Title: ______________________

Telephone #: (   ) ______________________ Fax #: (   ) ______________________

VII. LIMITATIONS ON WORK ACTIVITIES

If the individual has limitations due to a physical or mental health condition, do these limitations preclude the individual from working in competitive employment for at least 80 hours per month?

☐ Yes ☐ No

Are these restrictions expected to last: ☐ up to 6 months ☐ 6-12 months ☐ 12+ months ☐ permanent

Do you recommend referral to rehabilitation, including but not limited to, a mental health or alcohol/substance abuse, or a physical rehabilitation program? ☐Yes ☐ No If yes, please specify: ______________________________

VIII. SCREENING FOR POSSIBLE SSI REFERRAL

Based on the evidence available to you, does this individual have severe impairment(s) which has lasted, or is expected to last at least 12 months? IF YES, *please check*________Explain briefly: ______________________________

______________________________ If substance abuse is also found, would such impairment be expected to continue if use of drugs and/or alcohol were to cease? ☐Yes ☐ No

IX. HEALTH CARE PRACTITIONER'S INFORMATION

Health Care Practitioner's Name *(please print)*: ______________________ Medical Position: ______________________

Address: ______________________________

If a physician, Board eligible or Board certified specialty: ______________________ Tele.#: (   ) ____________ Fax #: (   ) ____________

Is this client a patient of the examining health care practitioner? ☐ Yes ☐ No If yes, for how long? _________

Date of Last Examination: ____________________

Signature of health care practitioner: **X**______________________________ Date: ______________