



**OKLAHOMA DEPARTMENT OF HUMAN SERVICES**



**Report of Physician's Examination**

**I. Patient identification:**

Last name		First		M.I.	Date
Street address			City		State Zip
Race	Sex	Date of birth	Applied for Social Security Administration (SSA) benefits <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>		
County name		County number	Case number	Client identification (ID) number	

Members of household other than patient: **None**  **Spouse**

Others  Specify by relationship: \_\_\_\_\_

**II. Medical history:** Relevant history including surgical procedures with approximate dates:

Present complaints:

**III. Visual and otological findings:**

<b>Right eye</b> <ul style="list-style-type: none"> <li>• Pterygium <input type="checkbox"/></li> <li>• Cataract <input type="checkbox"/></li> <li>• Corneal scars <input type="checkbox"/></li> <li>• Vision <ul style="list-style-type: none"> <li>• Normal <input type="checkbox"/></li> <li>• Impaired <input type="checkbox"/></li> <li>• Blind <input type="checkbox"/></li> <li>• Severely impaired <input type="checkbox"/></li> </ul> </li> </ul>	<b>Left eye</b> <ul style="list-style-type: none"> <li>• Pterygium <input type="checkbox"/></li> <li>• Cataract <input type="checkbox"/></li> <li>• Corneal scars <input type="checkbox"/></li> <li>• Vision <ul style="list-style-type: none"> <li>• Normal <input type="checkbox"/></li> <li>• Impaired <input type="checkbox"/></li> <li>• Blind <input type="checkbox"/></li> <li>• Severely impaired <input type="checkbox"/></li> </ul> </li> </ul>
<b>Hearing - right ear</b> <ul style="list-style-type: none"> <li>• Normal <input type="checkbox"/></li> <li>• Impaired <input type="checkbox"/></li> <li>• Severely impaired <input type="checkbox"/></li> </ul>	<b>Hearing - left ear</b> <ul style="list-style-type: none"> <li>• Normal <input type="checkbox"/></li> <li>• Impaired <input type="checkbox"/></li> <li>• Severely impaired <input type="checkbox"/></li> </ul>
Nose, mouth, and pharynx	

**IV. Other physical findings:**

Height	Weight	Blood pressure Systolic - _____ Diastolic - _____	Pulse rate	Urinalysis: Albmin - _____ Sugar - _____ Microscopic - _____
Lungs:				
Heart and circulatory system:				
Abdominal and pelvic:				
Orthopedic:				
Other significant findings:				

**V. Clinical diagnosis:**

Primary diagnosis	ICD-9-CM code	Onset date
Secondary diagnosis	ICD-9-CM code	Onset date
Prognosis		

**VI. Plan of treatment:**

Immediate orders:
Long range goals:
Restoration:
History of previous rehabilitation within past 12 months:
Rehabilitation feasibility:

**VII. Needed care:**

This patient is in need of:

- Skilled nursing facility (SNF) care
- ICF/Mentally Retarded (ICF/MR) care
- Home and Community Based a  
Waiver services
- Intermediate care facility (ICF) care
- Personal care
- ADvantage waiver
- Other

Conditions requiring special management:

- Ambulatory without help
- Ambulatory 
  - Cane
  - Crutch
  - Other person
- Chairfast
- Bedfast
- Uses bathroom without help
- Requires bedpan
- Incontinent
- Needs help bathing
- Needs help dressing
- Needs help following medical instructions
- Disorientated
- Non-cooperative
- Management problem  (Specify) \_\_\_\_\_

**VIII. Work tolerance**, if section VII does not indicate need for nursing care:

Standing	Walking	Bending	Lifting
----------	---------	---------	---------

Sedentary  Light  Moderate  Usual work

**IX. Name and address of examining physician - typed or printed:**

Last name	First	Date of examination	Date of report
Street address	City	State	Zip

OKDHS is authorized to furnish this report to any physician, medical facility, or medical provider having a need for the information herein.

---

Physician's signature
D. O.  M. D. 
Date