

MEDICAL REPORT FOR DETERMINATION OF DISABILITY  
NEW YORK STATE DEPARTMENT OF HEALTH  
STATE DISABILITY REVIEW UNIT

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## Reporting Requirements for Orthopedic Examinations

Please include the following in your narrative report:

1. Date(s) of your examination.
2. History obtained including:
  - a. Date(s) and description of the earliest symptoms.
  - b. Date(s) and reason(s) for any hospitalization(s).
  - c. Nature of treatment given with medication, dosage and frequency, if known, and response.
  - d. Other relevant history.
  - e. Typical daily activities.
3. Findings of a complete musculoskeletal system review including:
  - a. Site(s) of any deficit(s) in range of motion with remaining range of motion in degrees (you may use the enclosed Range of Motion (ROM) chart or dictate the deficits in your narrative report), observations noted during the examination, i.e., gait and station, how client got on and off the examining table, ability to walk on heels and toes, squat and arise from a squatting position. Where there is use of a hand held assistive device, the examination should be with and without the device (unless it is medically contraindicated). When there is involvement of the lower back, report the results of straight leg raising in BOTH the sitting and supine positions, including the reason for reporting a positive result. In lower extremity amputations, include a description of the stump without the prosthesis(es), describe the ability to ambulate with the prosthesis(es) including a description of the medical reason (s) for inability to ambulate effectively.

Note: The measurements of joint motion are based on the techniques described in the "Guides to the Evaluation of Permanent Impairment-the Extremities and Back": American Medical Association 5<sup>th</sup> Edition.

  - b. Site and severity of any motor (0-5 with 5 normal), sensory, and reflex abnormalities.
  - c. Description of any atrophies including: site, point of measurement (e.g., 2" above knee. etc.) and circumferential measurements of both the affected and unaffected extremities. If upper extremity muscles and/or cervical spine involved, include measurements of grip and pinch strength, and ability for fine and gross manipulations.
  - d. Site and severity of any anatomical deformities (contractures, subluxation, ankylosis, instability, enlargement or effusion).
  - e. In cases of rheumatoid activity give:
    - (1) Date current episode began.
    - (2) Current symptoms (if different from 2a).
    - (3) Joints involved with findings on examination (e.g., heat, swelling, tenderness, etc.)
  - f. Height and Weight (without shoes).
  - g. Results and interpretation of laboratory findings.
4. Diagnosis, including etiology and prognosis.
5. Describe any other significant condition present.

**RANGE OF MOTION CHART**

Patient's Name: \_\_\_\_\_

DIN #: \_\_\_\_\_

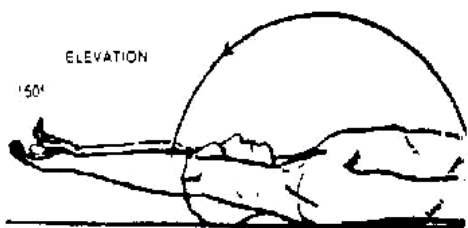
Diagnosis: \_\_\_\_\_

Please complete **ONLY** the sections of this chart which illustrate joints that have less than full range of motion. Proceed by filling in the degree at which motion stops. Sections left blank will be considered normal.

**SHOULDER**

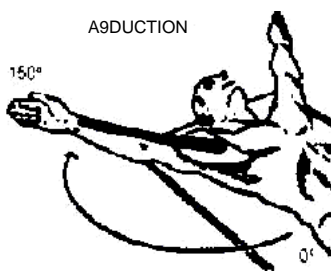
A. Forward Elevation (0°-150°)

Right \_\_\_\_\_ Left \_\_\_\_\_



B. Abduction (0°-150°)

Right \_\_\_\_\_ Left \_\_\_\_\_



C. Adduction (0°-30°)

Right \_\_\_\_\_ Left \_\_\_\_\_

D. Internal Rotation (0°-40°)

Right \_\_\_\_\_ Left \_\_\_\_\_

E. External Rotation (0°-90°)

Right \_\_\_\_\_ Left \_\_\_\_\_

**ELBOW**

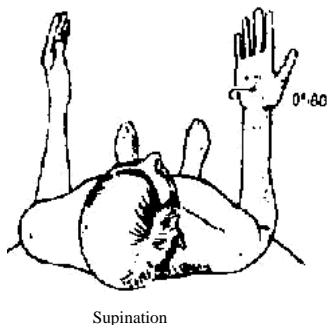
A. Flexion-Extension (0°-150°)

Right \_\_\_\_\_ Left \_\_\_\_\_



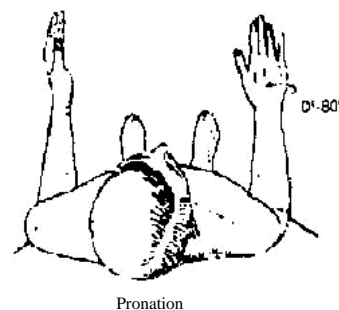
B. Supination (0°-80°)

Right \_\_\_\_\_ Left \_\_\_\_\_



C. Pronation (0°-80°)

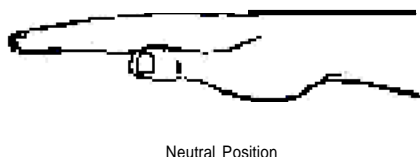
Right \_\_\_\_\_ Left \_\_\_\_\_



**WRIST**

A. Dorsiflexion (0°-60°)

Right \_\_\_\_\_ Left \_\_\_\_\_



B. Palmar Flexion (0°-70°)

Right \_\_\_\_\_ Left \_\_\_\_\_

C. Radial Deviation (0°-20°)

Right \_\_\_\_\_ Left \_\_\_\_\_

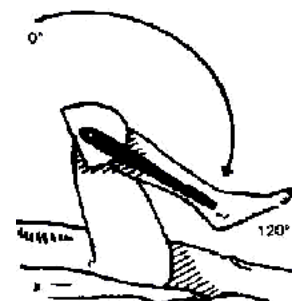
D. Ulnar Deviation (0°-30°)

Right \_\_\_\_\_ Left \_\_\_\_\_

**KNEE**

A. Flexion-Extension (0°-120°)

Right \_\_\_\_\_ Left \_\_\_\_\_



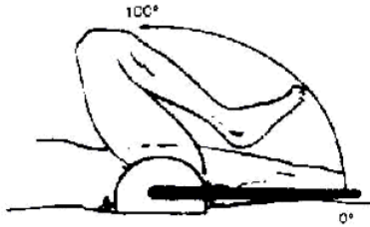
**RANGE OF MOTION CHART (Continued)**

Patient's Name: \_\_\_\_\_ DIN# \_\_\_\_\_

**HIP**

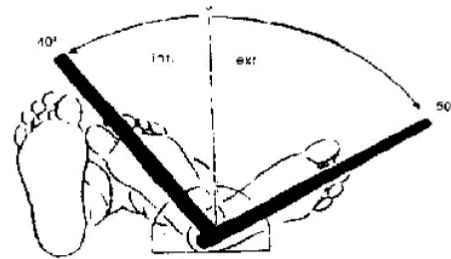
A. Forward Flexion (0°-100°)

Right \_\_\_\_\_ Left \_\_\_\_\_



C. Rotation-Interior (0°-40°)

Right \_\_\_\_\_ Left \_\_\_\_\_



Rotation-Exterior (0°-50°)

Right \_\_\_\_\_ Left \_\_\_\_\_

B. Backward Extension (0°-30°)

Right \_\_\_\_\_ Left \_\_\_\_\_

D. Abduction (0°-40°)

Right \_\_\_\_\_ Left \_\_\_\_\_

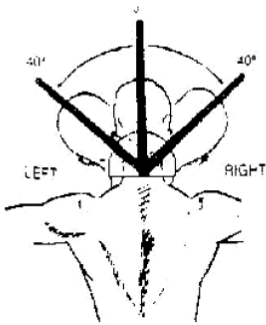
E. Adduction (0°-20°)

Right \_\_\_\_\_ Left \_\_\_\_\_

**SPINE (Cervical Region)**

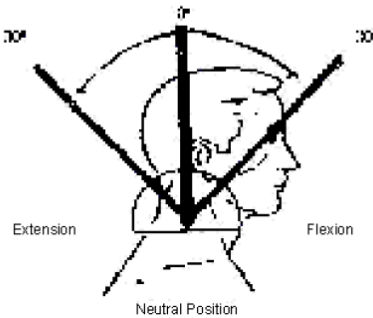
A. Lateral Flexion (0°-40°)

Right \_\_\_\_\_ Left \_\_\_\_\_



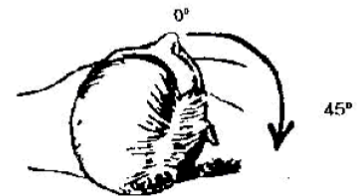
B. Flexion (0°-30°)

C. Extension (0°-30°)



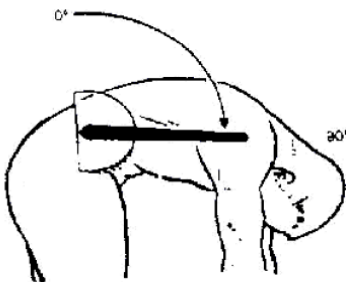
D. Rotation (0°-45°)

Right \_\_\_\_\_ Left \_\_\_\_\_



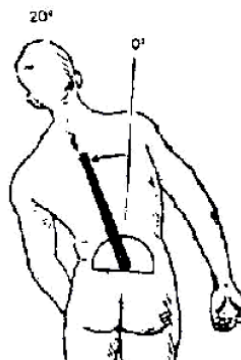
**SPINE (Lumbar Region)**

A. Flexion-Extension (0°-90°)



B. Lateral Flexion (0°-20°)

Right \_\_\_\_\_ Left \_\_\_\_\_



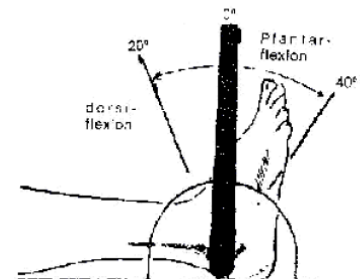
**ANKLE**

A. Dorsi-Flexion (0°-20°)

Right \_\_\_\_\_ Left \_\_\_\_\_

B. Plantar-Flexion (0°-40°)

Right \_\_\_\_\_ Left \_\_\_\_\_



## REPORTING REQUIREMENTS FOR MUSCULOSKELETAL EXAMINATION (Internist)

Please include the following in your narrative report.

1. Date(s) of your examination.
2. History obtained including:
  - a. Date(s) and description of the earliest symptoms.
  - b. Date(s) and reason(s) for any hospitalization(s).
  - c. Nature of treatment given, with type of medication, if known, and response.
  - d. Other relevant history.
  - e. Typical daily activities.
3. Findings on this examination including:
  - a. Height and weight (without shoes), blood pressure and pulse rate.
  - b. Specify joints involved, and describe findings (e.g. heat, swelling, tenderness, redness, limitation of motion or structural abnormalities.) You may use the enclosed ROM CHART to document any range of motion (ROM) deficits found or include these findings in your narrative report. Finger deficits should be described in terms of ability to make a fist, manipulate the fingers in performing fine and gross movements and in hand strength. Also include in your report observations noted during the examination, i.e., gait and station, how client got on and off the examining table, ability to walk on heels and toes, squat and rise from a squatting position (without the use of assistive device).
  - c. If active rheumatoid arthritis present, give date episode began.
  - d. Description of any sensory, motor (1-5 with 5 normal and reflex abnormalities).
  - e. Results and interpretation of laboratory findings.
4. Diagnosis, including etiology and prognosis.
5. Describe any other significant condition present.

## REPORTING REQUIREMENTS FOR SPINAL DISORDERS

Please include the following in your narrative report:

1. Date(s) of your examination.
2. History obtained including:
  - a. Date(s) and description of the earliest symptoms.
  - b. Date(s) and reason(s) for any hospitalization(s).
  - c. Nature of treatment given, with type of medication if known, and response.
  - d. Typical daily activities.
  - e. Other relevant history.
3. Findings on this examination including:
  - a. Height and weight (**without shoes**).
  - b. Description of gait and station.
  - c. Limitation of movement of the spine given quantitatively in degrees from the vertical position.
  - d. Sensory abnormalities.
  - e. Motor abnormalities (testing should include walking on heels and toes or arising from a squatting position without assistive device where appropriate).
  - f. Deep tendon reflexes.
  - g. Circumferential measurements of thigh and lower leg (or upper or lower arm) including actual measurements of both extremities at a stated point above and below the knee or elbow, given in inches or centimeters.
  - h. Result(s) and interpretation(s) of laboratory findings.
4. Your observation of the individual during the examination (i.e. how he or she gets on or off the examining table, stance, etc.)
5. Alternative testing used to objectively confirm abnormal findings (e.g. seated straight leg raising test in addition to supine straight leg raising test, etc.)
6. Diagnosis, including etiology and prognosis.
7. Describe any other serious condition significant to recovery.

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Exhibit 8

REPORTING REQUIREMENT FOR VISUAL IMPAIRMENTS

Please include the following in your narrative report:

- 1) Date(s) of your examination:
  - 2) History obtained including:
    - a) Date(s) and description of symptoms
    - b) Date(s) and reason(s) for any hospitalization(s)
    - c) Nature of treatment given, with type of medication, if known, and response.
    - d) Typical daily activities
    - e) Other relevant history
  - 3) Findings on your examination including:
    - a) Exact degree of central visual acuity for each eye including:
      - (1) Distant vision without correction.
      - (2) Distant vision with best correction. Give power of correcting lenses obtained by refraction.
- NOTE: The results of pinhole testing, automated refraction acuity, or a positive response to VER testing to determine best corrected visual acuity.
- (3) Distant vision with present prescription correction.
      - (4) Near vision correction using AMA, Snellen or Jaeger notation.
    - b) Tension in each eye.
    - c) Complete description of fundus.
    - d) Muscle function.
  - 4) Separate diagnoses for each eye, including etiology and prognosis.
  - 5) Describe any other significant condition present.
  - 6) Perform a test of visual fields. Acceptable equipment is Goldmann, Standard Arc or Humphrey Field Analyzer 30-2 or 24-2 threshold test. The "SSA Test Kinetic" can also be used. Automated kinetic testing should not be used if there is a significant limitation in the central visual field, such as a scotoma. Corrective spectacle lenses should not be worn during the exam. Please comment on the degree of cooperation and understanding during the field examination. Submit a copy of the visual field for both eyes. If the Humphrey SSA Test Kinetic is used, submit both the graphic printout and the numeric printout.

NOTE: Tangent screen visual fields are not acceptable as a measurement of peripheral visual fields. Field Master and similar types of perimeters which present targets at fixed points only are not acceptable.





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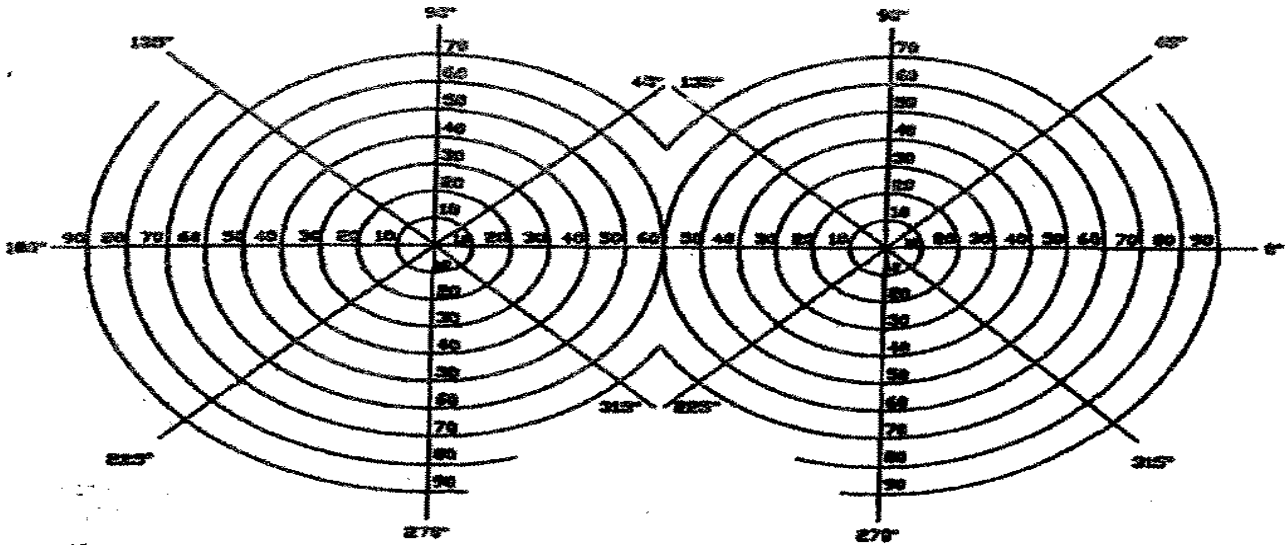
Exhibit 8

Please check the appropriate box(es) to show test object(s) used.

phakic      [ ] 3/330 White                      [ ] III, 4 e (Goldmann)  
aphakic    [ ] 6/330 White                      [ ] IV, 4 e (Goldmann)

LEFT EYE

RIGHT EYE



X

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE



REPORTING REQUIREMENTS FOR EXAMINATIONS FOR HEARING DISORDERS

Please perform examination and prepare your typewritten narrative report on your own stationary, pursuant to specifications and requirements outlined below. Perform only those tests and examinations which are authorized by the State Disability Review Unit.

A. For an ear examination the report must include:

1. Date(s) of your examination.
2. History obtained Including:
  - a. Date(s) and description of past and present symptoms.
  - b. Nature of treatment given and response.
  - c. Date(s) and reason(s) for any hospitalization(s).
  - d. Typical daily activities.
  - e. Other relevant history.
3. Findings on this examination, to include:
  - a. Complete ear examination.
  - b. Functional test of cochlea.
  - c. Audiometric test results. (Copy of the audiogram must accompany report- do not perform test with hearing aids.)
4. Diagnosis and prognosis.
5. Recommended treatment.
6. Describe any other significant condition present.

B. Additional testing with no cochlear implant:

1. Speech reception threshold (SRT) testing (also referred to as "spondee threshold" or "ST" testing), and word recognition testing (also referred to as "word discrimination" or "speech discrimination" testing). This testing must be conducted in a sound treated booth or room and must be in accordance with the most recently published standards of the American National Standards Institute (ANSI). Each ear must be tested separately and hearing aids must not be worn during the testing.
  - a. The SRT is the minimum dB level required for to recognize 50 percent of the words on a standard list of spondee words. (Spondee words are two-syllable words that have equal stress on each syllable.) The SRT is usually within 10 dB of the average pure tone air conduction hearing thresholds at 500, 1000, and 2000 Hz. If the SRT is not within 10 dB of the average pure tone air conduction threshold, the reason for the discrepancy must be documented.
  - b. Word recognition testing determines ability to recognize a standardized list of phonetically balanced monosyllabic words in the absence of any visual cues. This testing must be performed in quiet. The list may be recorded or presented live, but in either case the words should be presented at a level of amplification that will measure maximum ability to discriminate words, usually 35 to 40 dB above SRT. However, the amplification level used in the testing must be medically appropriate, and the individual must be able to tolerate it. If the Individual cannot be tested at 35 to 40 dB above SRT, the test should report word recognition testing score at the highest comfortable level of amplification.

C. Additional testing with cochlear implants

1. Word recognition testing performed with any version of the Hearing in Noise Test (HINT). This testing must be conducted in quiet, in a sound field. The implant must be functioning properly and adjusted to the individual's normal settings. The sentences should be presented at 60 dB HL (Hearing Level) and without any visual cues.

## REPORTING REQUIREMENTS FOR A COMPREHENSIVE SPEECH AND LANGUAGE EVALUATION

### Formal Testing for your Evaluation

Please administer a current, well-standardized comprehensive communication battery appropriate to the individual's age (and primary language, if available) that measures semantic and syntactic competency in both receptive and expressive modes.

#### Preferred tests include the most recent versions of:

- Sequenced Inventory Of Communication Development-Revised
- Preschool Language Scales
- Clinical Evaluation of Language Fundamentals
- Test Of Language Development
- Test Of Adolescent Language

Supplement formal test results with a parent questionnaire, as appropriate. For example,

- *Receptive-Expressive Emergent Language*
- *Rosetti Infant-Toddler Language Scales*

Include a current assessment tool, if needed, to validate ratings of intelligibility at the conversational/multiword level. Preferred tools are:

- Goldman Fristoe Test of Articulation
- Riley Stuttering Prediction Instrument/Riley Stuttering Severity Instrument
- Weiss Comprehensive Articulation Test

*If an individual is not a candidate for standardized testing, please describe the reason, administer informal testing, and provide clinical observations.*

When providing test results,

- Include the full title of the test as well as the test/subtest mean and standard deviation (SD).
- Report the individual's total language standard scores (SS), area composite SS's and individual subtest SS's (when these are part of the test protocol).
- Include operational definitions of terms, if appropriate.
- Discuss the validity of the test results relative to the individual's behavior (cooperation, interest and attention/concentration).
- Include completed test protocols with your evaluation report.
- Correct chronologic age for prematurity later in your report when you compare the child with same age typically developing peers. Generally, correct for prematurity for all children who have not attained age one year. Correct for children over one year of age where a child has a developmental delay and prematurity is still a factor in that delay. Comment whether you are using corrected age in your comparison.

**Please also include the following in your report:**

Date(s) of your evaluation

Developmental history

- Informant
- Reported speech and language problems, with specific examples
- Birth and post-natal medical history (including prematurity, feeding problems, ear infections or hearing loss, use of PE tubes or hearing aid(s)), developmental problems in other areas, and family history of communication problems
- Previous/current speech-language therapy and progress made
- Primary language, language used in the home, and language of instruction (if the household is bilingual or non-English speaking)
- Age when a child (under age three years at evaluation) achieved speech-language milestones including cooing, babbling, first words, phrases, sentences

### **Comprehensive Speech Testing**

- Oral peripheral examination
  - Oral structures. oral-motor mechanisms. voluntary movements (imitative)
  - Note unusual oral-motor behaviors (excess drooling/mouthing objects)
- Clinical observations of articulation, voice, and fluency, comparing with typically developing same age peers and with individual's cognitive level (if known)
- Description of speech intelligibility in percentages of conversational level, with familiar/non-familiar listeners, when topic is known/unknown, if relevant to the child's age/experience
  - Note child's ability to improve intelligibility upon repetition/imitation of message, noting the percent of speech that is intelligible after repetition/imitation
- Patterns of articulation errors or phonologic process, advising whether developmental, delayed or atypical for age.
  - Note contributing effect of motor-based speech disorders or use of dialectal variations.
- As appropriate, for child under three years at exam, and based upon observed skill level,
  - Description of sounds in child's repertoire (with frequency of use), play with sounds, stage of sound-making, use of sound patterns/combinations.
  - Comment on whether sound patterns are typical, delayed or atypical and whether speech is sufficient to support development of expressive language. If pattern is atypical or delayed, provide a description.

### **Comprehensive Language Testing**

- Clinical observations (and caregiver's report) of spontaneous language understanding and production. Compare with same age typically developing peers
- Comments on the individual's overall receptive language skills and overall expressive skills in spontaneous conversation (e.g., MLU, syntax)
- Discussion of the individual's conversational/pragmatics skills relative to individual's chronologic age, e.g.,
  - Range of communicative intentions
  - Turn-taking (verbal/nonverbal), topic maintenance, repair of miscommunications, ability to account for listener's understanding
  - Use of gestures, reciprocal eye gaze/joint referencing
- Size of vocabulary, frequency/quality of multiword utterances, length of utterances
- Narrative skills relative to age expectations (individuals over three years), e.g., retell events, sequence events, use basic story structure, use pronouns/conjunctions for coherence

### **Assessment statement**

- Correlate communicative functioning with findings from the history, observations and formal testing (language comprehension, language expression, speech production)
  - Comment on the impact of factors such as recurrent otitis media, orofacial/physical anomalies
  - Comment whether the language test profile reflects the child's every-day or school language skills
- Explain all abnormalities or comment if an explanation cannot be provided
- Describe how the speech and/or language disorder would likely affect the child's activities, learning, and/or social development [Discuss impact of the disorder(s) on the ability to perform work activities in adults.]
- Prognosis for improvement over the next twelve months

**Please remember to sign your report and include your credentials.**

## REPORTING REQUIREMENTS FOR PULMONARY DISORDERS

Please include the following in your narrative report.

1. Date(s) of your examination.
2. History obtained including:
  - a. Date(s) and description of past and present symptoms.
  - b. Frequency and duration of any acute episodes of respiratory distress. Include all hospital and emergency room visits for acute episodes in the past year, giving dates, if known, and description of treatment, i.e., IV drug administration or inhalation therapy, length of stay for each visit (hours, days).
  - c. Medication, including dosage and frequency.
  - d. Other relevant history.
  - e. Typical daily activities.
3. Findings on this examination including:
  - a. Height and weight (**without shoes**), blood pressure and pulse rate.  
(Note: if spinal curvature distorts height, substitute arm span).
  - b. Presence of dyspnea, prolonged expiration, wheezing, rales or rhonchi.
4. Results and interpretation of laboratory findings and tests ordered.
5. Diagnosis and prognosis.
6. Recommended treatment.
7. Describe any other significant condition(s) present.

**PULMONARY FUNCTION TEST RESULTS**

1. Date of Testing \_\_\_\_\_ 2. Age \_\_\_\_\_ 3. Sex \_\_\_\_\_  
4a. Height (without shoes) \_\_\_\_\_ 4b. If spinal curvature, substitute arm span \_\_\_\_\_  
5. Weight \_\_\_\_\_ 6a. Manufacturer \_\_\_\_\_ 6b. Model# \_\_\_\_\_  
7. If bronchodilators administered, enter name \_\_\_\_\_ dosage \_\_\_\_\_  
8. The largest value of at least three satisfactory forced expiratory maneuvers \_\_\_\_\_

Test	Predicted	Observed Before Bronchodilators	Observed After Bronchodilators
Total Forced Vital Capacity (FVC) BTPS	L.	L.	L.
One second forced expiratory volume (FEV1) BTPS	L/sec.	L/sec.	L/sec.

9. In requests sent to you asking only for ventilation test before bronchodilators, if wheezing or bronchospasm is present on physical examination, or if the values obtained are less than 70 percent predicted values, then testing after bronchodilators must be performed, unless there is a medical contraindication to the use of nebulized bronchodilators.

10. Was the client in acute distress? \_\_\_\_\_  
11. Is wheezing present on auscultation of the chest? \_\_\_\_\_  
12. State client's ability to understand directions for performing tests. \_\_\_\_\_  
\_\_\_\_\_  
13. Describe client's cooperation in performing tests. \_\_\_\_\_  
\_\_\_\_\_  
14. Describe nature and severity of any impairment found and comment on the correlation between the test results and the findings on your examination. \_\_\_\_\_  
\_\_\_\_\_  
15. Please advise the physician who is to receive a copy of your report (if requested). If you cannot perform any part of the ordered testing at this time, state the reason. If you need to speak directly to the State Disability Review Unit regarding this client, the physician can provide you with the contact information.

X  
\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE

**PULMONARY FUNCTION TESTING REQUIREMENTS**

1. The results of spirometry should be expressed in liters (L), body temperature and pressure saturated with water vapor (BTPS).
2. The reported one second forced expiratory volume (FEV<sub>1</sub>) and forced vital capacity (FVC) should represent the largest of at least three satisfactory forced expiratory maneuvers.
3. Two of the satisfactory spirograms should be reproducible for both pre-bronchodilator tests and, if indicated, post-bronchodilator tests. A value is considered reproducible if it does not differ from the largest value by more than 5 percent or 0.1L, whichever is greater.
4. Peak flow should be achieved early in expiration, and the spirogram should have a smooth contour with gradually decreasing flow through expiration.
5. The zero time for measurement of the FEV<sub>1</sub> and FVC, if not distinct, should be derived by linear back-extrapolation of peak flow to zero volume. A spirogram is satisfactory for measurement of the FEV<sub>1</sub> if the expiratory volume at the back-extrapolated zero time is less than 5 percent of the FVC or 0.1L, whichever is greater.
6. The spirogram is satisfactory for measurement of the FVC if maximal expiratory effort continues for at least 6 seconds, or if there is a plateau in the volume-time curve with no detectable change in expired volume (VE) during the last 2 seconds of maximal expiratory effort.
7. Spirometry should be repeated after administration of an aerosolized bronchodilator under supervision of the testing personal if the pre-bronchodilator FEV<sub>1</sub> value is less than 70 percent of the predicted normal value. Post-bronchodilator testing should be performed 10 minutes after bronchodilator administration. The dose and name of the bronchodilator administered should be specified. If bronchodilator is not administered, the reason should be clearly stated in the report.
8. Pulmonary function studies should not be performed unless the clinical status is stable (e.g. the individual is not having an asthmatic attack or suffering from an acute respiratory infection).
9. The spirometric tracing should show distance per second on the abscissa and distance per liter on the ordinate.
10. The testing device must accurately measure both time and volume, the latter to within 1 percent of a 3L calibrating volume.
11. If the spirogram is generated by any other means other than direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show a recorded calibration of volume units using a mechanical volume input such as a 3L syringe.
12. If the spirometer directly measures flow, and volume is derived by electronic integration, the linearity of the device must be documented by recording volume calibrations at three different flow rates of approximately 30L/min (3L/6 sec), 60L/min (3L/3 sec), and 180L/min (3L/sec). The volume calibrations should agree to within 1 percent of a 3L calibrating volume. The proximity of the flow sensor to the individual should be noted, and it should be stated whether or not a BTPS correction factor was used for the calibration recordings and for the individual's actual spirograms.
13. The spirograms must be recorded at a speed of at least 20 mm/sec, and the recording device must provide a volume excursion of at least 10 mm/L
14. If reproductions of the original spirometric tracings are submitted, they must be legible and have a time scale of at least 20 mm/sec and a volume scale of at least 10 mm/L.
15. Calculation of FEV<sub>1</sub> from a flow-volume tracing is not acceptable.



## REPORTING REQUIREMENTS FOR EXERCISE ARTERIAL BLOOD GAS STUDIES

### 1. General:

- a. Resting test should be performed while breathing room air, awake and sitting or standing.
- b. Do exercise testing:
  - Only if DLCO <60% of predicted;
  - and exercise is not a risk for the individual (If a risk and exercise not done. explain in writing).

### 2. Methodology:

- a. Take resting arterial blood determinations of:
  - partial pressure of oxygen (PO<sub>2</sub>),
  - resting arterial blood partial pressure of carbon dioxide (PCO<sub>2</sub>), and
  - negative log of hydrogen ion concentration (pH).
- b. Warm-up period (treadmill walking or cycling) to acquaint individual with procedure to be done.
- c. Exercise:
  - Individual should perform steady state exercise, preferably on a treadmill for 4-6 minutes at 5 METS (17.5 ml/kg/min.). If individual cannot achieve 5 METS during warm-up, a lower workload in keeping with estimate of exercise capacity, may be used.
  - If exercise is on a bicycle ergometer, equivalent of 5 METS should be used (e.g., 450 kpm/min., or 75 watts, for a 176 lbs./80 kg. person).
  - If blood gas results at 5 METS exceed the values below, exercise should proceed to higher workloads.
- d. Monitoring:
  - ECG should be continued throughout exercise and in immediate post-exercise period.
  - ECG and blood pressure should be recorded during each minute of exercise.
- e. Drawing blood:
  - (1) During final 2 minutes of a specific level of steady state exercise, arterial blood sample should be drawn and analyzed for:
    - oxygen pressure (PO<sub>2</sub>),
    - carbon dioxide pressure (PCO<sub>2</sub>),
    - negative log of hydrogen ion concentration (pH).
  - (2) Sample may be obtained from an indwelling arterial catheter or by direct arterial puncture.
  - (3) If possible, measure minute ventilation, O<sub>2</sub> consumption, and CO<sub>2</sub> production.

### 3. Reporting:

- a. If individual fails to complete 4-6 minutes of steady state exercise, comment on the reason and report actual duration and levels of exercise performed.
- b. Provide:
  - Representative strips of ECG taken before, during and after exercise;
  - Resting and exercise arterial blood gas values;
  - Treadmill speed and grade settings (or exercise levels in watts or kpm/min. if bicycle ergometer);
  - Duration of exercise;
  - Body weight;
  - O<sub>2</sub> consumption (STPD), minute ventilation (BTPS), and CO<sub>2</sub> production (STPD), if measured;
  - Altitude of test site, normal range of blood gas values, and barometric pressure on test date.

**TEST RESULTS**

Client: \_\_\_\_\_ Disability ID # \_\_\_\_\_ Date: \_\_\_\_\_

Altitude of test site: \_\_\_\_\_ Barometric pressure: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Exercise:

Completed: \_\_\_\_\_ mph at \_\_\_\_\_ % grade for \_\_\_\_\_

Prematurely terminated because: \_\_\_\_\_

Not completed because: \_\_\_\_\_

Symptoms during and after exercise: \_\_\_\_\_

	Pre-exercise	Exercise
PO <sub>2</sub> (mmHg)		
PCO <sub>2</sub> (mmHg)		
pH(mmHg)		

Minute ventilation (BTPS)	
o <sub>2</sub> consumption/min (STPD)	
co <sub>2</sub> production (STPD)	

The above test was performed and reported according to the criteria specified above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name & title: \_\_\_\_\_

**REPORTING REQUIREMENTS FOR CARDIOVASCULAR DISORDERS**

Please include the following in your narrative report:

1. Date (s) of your examination.
2. History obtained including:  
Date (s) and description of the earliest symptoms.
  - a. Date (s) and reason (s) for any hospitalization(s).
  - b. Nature of treatment given, with type and total daily dosages of medication, if known and response.
  - c. Other relevant history.
  - d. Typical daily activities.
3. Findings on this examination including:
  - a. Present symptoms (if chest pain is alleged include the following):

(1) Character of Pain	(5) Duration of pain
(2) Location	(6) Mode of relief
(3) Sites of radiation	(7) Frequency of episodes
(4) Precipitating factors	(8) Syncope
  - b. Height and weight (**without shoes**), blood pressure and heart rate.
  - c. Findings and fundoscopic examination.
  - d. Heart sounds.
  - e. Evidence of dyspnea.
  - f. Any physical sign of congestive heart failure (e.g. hepatomegaly, peripheral or pulmonary edema).
  - g. Any evidence of cerebral involvement.
4. Results and interpretation of clinical and laboratory findings (see attached test results).  
**IMPORTANT: If chest pain of seeming cardiac origin is alleged, and the resting ECG is determined to be within normal limits, call the State Disability Review Unit for approval to administer an exercise ECG.**  
  
**Resting ECGs taken either as a single request or as a preliminary to an exercise test must include a tracing of leads III and aVF on deep inspiration. Submit identified tracings.**
5. Diagnosis, includes etiology and basis for your conclusion,
6. Prognosis,
7. Describe any other significant condition present.

**IMPORTANT NOTICE: THESE INSTRUCTIONS HAVE BEEN REVISED DUE TO  
CHANGES IN FEDERAL RULES, EFFECTIVE IMMEDIATELY**

**TREADMILL EXERCISE ELECTROCARDIOGRAPH TEST REQUIREMENTS**

This form must be given to the physician administering the treadmill test.

1. ECGs obtained in conjunction with treadmill, bicycle or arm exercise tests should meet the following specifications:
  - a. ECGs must include the original calibrated ECG tracing or a legible copy.
  - b. A 12-lead baseline ECG must be recorded in the upright position.
  - c. A 12-lead ECG should be recorded at the end of each minute of exercise, including at the time the ST segment abnormalities reach or exceed the criteria for abnormality described in #4 below or the individual experiences chest discomfort or other abnormalities, and also when the exercise test is terminated.
  - d. If ECG documentation of the effects of hyperventilation is obtained, the exercise test should be deferred for at least 10 minutes because metabolic changes of hyperventilation may alter the physiologic and ECG response to exercise.
  - e. Post-exercise ECGs should be recorded using a generally accepted protocol (such as the Bruce Protocol) consistent with the prevailing state of medical knowledge and clinical practice.
  - f. All resting, exercise and recovery ECG strips must have a standardization inscribed on the tracing. The ECG strips should be labeled to indicate the times recorded and the relationship to the stage of exercise protocol. The speed and grade (treadmill test) or work rate (bicycle or arm ergonomic test) should be recorded. The highest level of exercise achieved, blood pressure levels during testing and the reason(s) for terminating the test (including limiting signs of symptoms) must be recorded.
2. Methodology
  - a. The exercise test should be a 'sign or symptom-limited' test characterized by a progressive multistage regimen. A description of the protocol that was followed must be provided. A pre-exercise post-hyperventilation tracing may be essential for the proper evaluation an 'abnormal' test in certain circumstances, such as in women with the evidence of mitral valve prolapse.
  - b. The exercise test should be paced to the capabilities of the individual and be supervised by a physician. With a treadmill test, the speed, grade, (incline) and duration of exercise must be recorded for each exercise test stage performed. Other exercise test protocols or techniques that are used should utilize similar workloads.
  - c. Levels of exercise should be described in terms of workload and duration of each stage, e.g., treadmill speed and grade, or bicycle ergometer work rate in kpm/min or watts.

3. Exercise testing should not be performed for individuals who have the following:
  - a. Unstable angina not previously stabilized by medical treatment.
  - b. Uncontrolled cardiac arrhythmias causing symptoms or hemodynamic compromise.
  - c. An implanted cardiac defibrillator.
  - d. Symptomatic severe aortic stenosis.
  - e. Uncontrolled symptomatic heart failure.
  - f. Aortic dissection.
  - g. Severe pulmonary hypertension (pulmonary artery systolic pressure greater 60 mm Hg).
  - h. Left main coronary stenosis of 50 percent or greater that has not been bypassed.
  - i. Moderate stenotic valvular disease with a systolic gradient across the aortic valve of 50 mm Hg or greater.
  - j. Severe arterial hypertension (systolic greater than 200 mm Hg or diastolic greater than 110 mm Hg).
  - k. Hypertrophic cardiomyopathy with a systolic gradient of 50 mm Hg or greater, or another impairment affecting the individual's ability to use their arms and legs.

In addition, an exercise test should not be performed on individuals for whom the performance of the test is considered a significant risk.

4. Criteria for a positive test: Symptom and sign-limited exercise test demonstrating at least one of the following manifestations at a workload equivalent to 5 METs or less:

1. Ischemic Heart Disease

- a. Horizontal or downsloping depression, in the absence of digitalis glycoside treatment or hypokalemia, of the ST segment of at least -0.10 millivolts (-1.0 mm) in at least 3 consecutive complexes that are on a level baseline in any lead other than aVR, and depression of at least -0.10 millivolts lasting for at least 1 minute of recovery; or
- b. At least 0.1 millivolt (1 mm) ST elevation above resting baseline in non-infarct leads during both exercise and 1 or more minutes of recovery; or
- c. Decrease of 10 mm Hg or more in systolic pressure below the baseline blood pressure or the preceding systolic pressure measured during exercise due to left ventricular dysfunction, despite an increase in workload.

2. Chronic Heart Failure

- a. Dyspnea, fatigue, palpitations, or chest discomfort; or
- b. Three or more consecutive premature ventricular contractions (ventricular tachycardia), or increasing frequency of ventricular ectopy with at least 6 premature ventricular contractions per minute; or
- c. Decrease of 10 mm Hg or more in systolic pressure below the baseline systolic blood pressure or the preceding systolic pressure measured during exercise (see section 4.00 D4d of the Medicaid Disability Manual) due to left ventricular dysfunction, despite an increase in workload; or
- d. Signs attributable to inadequate cerebral perfusion, such as ataxic gait or mental confusion.

MEDICAL REPORT FOR DETERMINATION OF DISABILITY  
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 STATE DISABILITY REVIEW UNIT

Exhibit 8

BRUCE PROTOCOL

1. Client:			2. Disability ID #			3. MOD/UNIT		
3. Date of Test:		4. Age:		5. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Height Ft.      In.		7. Weight
Stage	Grade	Speed MPH	Time (Min.)	Elapsed Test Time	Blood Pressure		Heart Rate	
					Systolic	Diastolic		
Rest								
I	10%	1.7	0-1	1.				
			1-2	2.				
			2-3	3.				
II	12%	2.5	0-1	4.				
			1-2	5.				
			2-3	6.				
III	14%	3.4	0-1	7.				
			1-2	8.				
			2-3	9.				
IV	16%	4.2	0-1	10.				
			1-2	11.				
			2-3	12.				
V	18%	5	0-1	13.				
			1-2	14.				
			2-3	15.				
VI	20%	5.5	0-1	16.				
			1-2	17.				
			2-3	18.				
VII	22%	6	0-1	19.				
			1-2	20.				
			2-3	21.				
Recovery Period			0-1	22.				
			1-2	23.				
			2-3	24.				
			3-4	25.				
			4-5	26.				
5-6								
27.								
8. If test curtailed, complete items 12-20, as appropriate								
9. Give medication client is taking with dosages and frequency.								
10. Detailed description of all ECG abnormalities:								
11. Interpretation of test findings								
Physician's signature				Facility			Date	

Treadmill Termination

CLIENT:	DISABILITY ID #:	MOD/UNIT:
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Please complete the items below if the treadmill test, which was not contraindicated per instructions on page 2 of the Treadmill Exercise electrocardiograph test requirements (Exhibit 8 page 19), and which purpose and procedures you will have explained to the client, is discontinued prior to attaining 5 METS (end of stage 1 in Bruce Protocol). Replies must be complete and detailed.

Treadmill stopped due to: (check one)       Cardiac Reasons (complete items 12-15)       Non-cardiac Reasons (complete items 16-20)

**Cardiac Reason(s):**

Your answers to questions 12, 13, and 14 a-c should be based on your observations and responses elicited from the client before you decided to stop the test.

12.  ECG changes are positive under criteria listed above on page 2 of the Treadmill Exercise electrocardiograph test requirements (Exhibit 8 page 19), item 4. Specify:

\_\_\_\_\_  
\_\_\_\_\_

13.  Fall in blood pressure: Give details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

14.  Allegation of chest discomfort of myocardial ischemic Origin: (complete items a-e)

a. Give client's description of chest discomfort: \_\_\_\_\_

b. Where was chest discomfort located? \_\_\_\_\_

c. Did chest discomfort radiate?       Yes       No      If so, where?

\_\_\_\_\_  
\_\_\_\_\_

d. How long did the chest discomfort last after exercise was stopped?

\_\_\_\_\_

e. How did the client obtain relief? \_\_\_\_\_

\_\_\_\_\_

15.  Other Cardiac: Specify: \_\_\_\_\_

\_\_\_\_\_

MEDICAL REPORT FOR DETERMINATION OF DISABILITY  
NEW YORK STATE DEPARTMENT OF HEALTH  
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Exhibit 8

**Non-Cardiac Reasons:** Please answer question 16 in addition to 17-20 as appropriate:

16. Was client evaluated prior to treadmill testing to determine ability to perform test?

a.  Yes, treadmill was performed after evaluation because:

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---

b.  No, pre-treadmill evaluation was not performed because:

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---

17.  Shortness of breath: Give complete description of your observations before you decided to stop the test.

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18.  Orthopedic: If test was stopped due to orthopedic complaints specify complaint and give description of your observations **before** the test was stopped.

19.  Fatigue: Specify complaint and describe any findings noted at the time of curtailment

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20.  Other Non-Cardiac: Specify \_\_\_\_\_

---

---

**Reminder Note:** Please be sure that your narrative report contains a full description of the client's daily activities, the level of activity which causes chest discomfort and a complete description of any chest discomfort.

Signature: \_\_\_\_\_ M.D. Date: \_\_\_\_\_



Client: \_\_\_\_\_ Disability ID # \_\_\_\_\_

IMPORTANT NOTICE: THESE INSTRUCTIONS HAVE BEEN REVISED DUE  
TO CHANGES IN FEDERAL RULES, EFFECTIVE IMMEDIATELY  
REPORTING REQUIREMENTS FOR PERIPHERAL VASCULAR EXAMINATIONS

Please include the following in your narrative report:

1. Date(s) of your examination.
2. History obtained including:
  - a. If evaluating chronic venous insufficiency comment on complaints in detail, i.e., pain, edema, how long ulceration has been present, if ulceration healed, how long healed, treatment given.
  - b. If evaluating chronic peripheral arterial insufficiency, comment on complaints in detail, i.e., description of intermittent claudication, inciting factors, nature and location of pain, severity, duration, treatment given.
    - (i) for brawny edema, provide detailed description
  - c. Typical daily activities.
3. Findings on this examination including;
  - a. Height and weight (without shoes), blood pressure, pulse rate.
  - b. Indicate the presence or absence of the following: pigmentation, cyanosis, ulceration, eczema, pallor, coldness, brawny edema stasis, dermatitis. If any of these are present give duration and severity.
  - c. If deep venous return is compromised indicate methods used in determining involvement.
  - d. The presence or absence of pulsation in the femoral artery, popliteal artery, posterior tibial artery, dorsalis pedis artery.
4. Diagnosis and Prognosis.
5. Recommended treatment.
6. Describe any other significant condition present.
7. If Arterial Doppler testing was ordered by our office, please see the specifications below and the next page.

**ARTERIAL BLOOD FLOW STUDIES USING THE DOPPLER TECHNIQUE**

**Technique:** Arterial blood flow measurements are to be performed before, and, if indicated, after exercise. A/B ratios should be calculated by dividing the systolic blood pressure determined in the ankle by the Doppler Technique (A) by the measured brachial systolic blood pressure (B). A/B values are expressed by the ratio of the two numbers.

Exercise is to be done on a treadmill for 5 minutes at 12% elevation at 2mph. Do not perform this test if medically contraindicated ((i) Unstable angina not previously stabilized by medical treatment. (ii) Uncontrolled cardiac arrhythmias causing symptoms or hemodynamic compromise. (iii) An implanted cardiac defibrillator. (iv) Symptomatic severe aortic stenosis. (v) Uncontrolled symptomatic heart failure. (vi) Aortic dissection. (vii) Severe pulmonary hypertension (pulmonary artery systolic pressure greater than 60 mm Hg). (viii) Left main coronary stenosis of 50 percent or greater that has not been bypassed. (ix) Moderate stenotic valvular disease with a systolic gradient across the aortic valve of 50 mm Hg or greater. (x) Severe arterial hypertension (systolic greater than 200 mm Hg or diastolic greater than 110 mm Hg). (xi) Hypertrophic cardiomyopathy with a systolic gradient of 50 mm Hg or greater; or another impairment affecting the individual's ability to use their arms and legs) or if the highest A/B ratio (either dorsalis pedis or posterior tibial) is less than 0.50 in either extremity, or if the highest A/B ratio is greater than 0.80 in both extremities.

All tracings generated by these studies are to be attached to the final report.

MEDICAL REPORT FOR DETERMINATION OF DISABILITY  
 NEW YORK STATE DEPARTMENT OF HEALTH  
 STATE DISABILITY REVIEW UNIT

Exhibit 8

Pre-Exercise Period				
Brachial Systolic Blood Pressure		Right: _____		Left: _____
	Right		Left	
	Systolic Pressure	A/B Ratio (Using higher brachial pressure)	Systolic Pressure	A/B Ratio (Using higher brachial pressure)
Dorsalis Pedis				
Posterior Tibial				

Post-Exercise Period				
Exercise not done because: _____				
Exercise accomplished: 2 mph at 10% or 12% elevation for _____ minutes.				
Symptoms during and after exercise: _____				
Premature termination of exercise due to: _____				
	Right Post-Exercise		Left Post-Exercise	
	Record Systolic Pressures Only			
	Immediate	10 Minutes	Immediate	10 Minutes
Dorsalis Pedis				
Posterior Tibial				
<b>NOTE: Please return this form with your report.</b>				
Physician's Signature			Date:	
X _____			_____	

Resting Toe Doppler

Resting Toe pressure should be measured by using any blood pressure cuff that fits snugly around the big toe and is neither too tight nor too loose. A neonatal cuff or a cuff designed for use on fingers or toes can be used in the measurement of toe pressure.

**REPORTING REQUIREMENTS FOR DIGESTIVE SYSTEM**

Please include the following in your narrative report:

1. Dates(s) of your examination.
2. History obtained including:
  - a. Past and present symptoms with dates and severity (i.e., pain, hemorrhage, jaundice, anorexia, nausea, vomiting, diarrhea, weakness, arthritis, iritis, fever).
  - b. Dates(s) and reason(s) for any hospitalization(s).
  - c. Present treatment.
  - d. Typical daily activities.
3. Findings on this examination including:
  - a. Height and weight (without shoes), pulse rate, blood pressure and physical appearance.
  - b. Presence of fistulae or external diversionary procedures and present condition (i.e., discharge, odor, prolapse, etc.) with duration and severity.
4. Results and interpretation of laboratory findings.
5. Diagnosis and prognosis.
6. Recommended treatment.
7. Describe any other significant condition present.

REPORTING REQUIREMENTS FOR GENITO-URINARY IMPAIRMENTS

Please include the following in your narrative report.

1. Date (s) of your examination.
2. History obtained including:
  - a. Description of past and present symptoms, i.e., pain (onset, nature, location, severity, duration), presence of pruritus (onset, location, severity, duration), and weight loss (onset, amount).
  - b. Date (s) and reason (s) for any hospitalization(s).
  - c. Treatment given.
  - d. Other relevant history.
  - e. Typical daily activities.
3. Findings on this examination including:
  - a. Height and weight (without shoes), blood pressure and pulse rate.
  - b. Positive and relevant negative findings, (i.e., edema, evidence of pruritus, weight loss).
4. Results and interpretation of laboratory findings.
5. Diagnosis and Prognosis.
6. Recommended treatment.
7. Describe any other significant condition present.

**REPORTING REQUIREMENTS FOR HEMIC AND LYMPHATIC SYSTEM**

Please include the following in your narrative report.

1. Date(s) of your examination.
2. History obtained including:
  - a. Dates and description of past and present symptoms, (i.e., onset, nature, severity, duration, frequency.)
  - b. Date(s) and reason(s) for any hospitalization(s).
  - c. Nature of treatment given (i.e., transfusions with dates, etc.)
  - d. Typical daily activities.
3. Findings on this examination including:
  - a. Height and weight (**without shoes**), blood pressure and pulse rate.
  - b. Positive and relevant negative findings.
4. Results and interpretation of laboratory findings.
5. Diagnosis and Prognosis.
6. Recommended treatment.
7. Describe any other significant condition present.

**REPORTING REQUIREMENTS FOR SKIN IMPAIRMENTS**

Please include the following in your narrative report:

1. Date (s) of your examination.
2. History obtained including:
  - a. Description of present symptoms (i.e., pruritus, ulceration, eczema, edema, weight loss, motion loss, pain, etc.) with onset date, location, severity and duration.
  - b. Treatment given (i.e., drugs, radiation, etc.) and response.
  - c. Typical daily activities.
3. Findings on this examination including:
  - a. Height and weight (**without shoes**), blood pressure and pulse rate.
  - b. Positive and relevant negative findings (nature and extent, joint involvement, range of motion, etc.)
4. Results and interpretation of laboratory findings.
5. Diagnosis and Prognosis.
6. Recommended treatment.
7. Describe any other significant condition present.

## REPORTING REQUIREMENTS FOR ENDOCRINE SYSTEM

Please include the following in your narrative report.

1. Date(s) of your examination.
2. History obtained including:
  - a. Description of present symptoms (i.e., weakness, weight loss, neuropathy, tetany, syncope, progressive exophthalmos, etc.) with onset date, severity, duration and frequency.
  - b. Date(s) and reason(s) for any hospitalization(s).
  - c. Treatment given with type and dosage of medication, if known and response.
  - d. Other relevant history (i.e., body system involvement, etc.)
  - e. Typical daily activities.
3. Findings on this examination including:
  - a. Height and weight (**without shoes**), blood pressure and pulse rate.
  - b. Organ involvement (eye, heart, kidney, cerebral).
  - c. Neuropathy, disturbances in gait, station, fine and gross movements, atrophy, etc.
  - d. Peripheral vascular findings.
4. Results and interpretation of laboratory findings.
5. Diagnosis and Prognosis.
6. Recommended treatment.
7. Describe any other significant condition present.

## REPORTING REQUIREMENTS FOR NERVOUS SYSTEM

Please include the following in your narrative report.

1. Dates(s) of your examination.
2. History obtained including:
  - a. Dates and description of past and present symptoms (onset, severity, duration, frequency) i.e., weakness, weight loss, rigidity, tremor, aphasia, speech, hearing, or visual difficulties, gait abnormalities, numbness, paresthesias, headaches.
  - b. Date(s) and reason(s) for any hospitalization(s).
  - c. Treatment given.
  - d. Other relevant history.
  - e. Typical daily activities.
3. Findings on this examination including:
  - a. Height and weight (**without shoes**), blood pressure and pulse rate.
  - b. Positive and pertinent negative findings, including:
    - (1) Site and description of motor weakness, atrophy, sensory changes, reflex changes, cranial nerve deficits, tremor, rigidity, bradykinesia.
    - (2) Description of the effect of the above on gait and station, hand and finger dexterity.
    - (3) Description and assessment of the severity of any speech disturbance including aphasia.
    - (4) Evidence of organic mental dysfunction.
    - (5) Description of personality changes (e.g., appearance, thought content, affect).
4. Results and interpretation of laboratory findings.
5. Diagnosis and Prognosis.
6. Recommended treatment.
7. Describe any other significant condition present.



## REPORTING REQUIREMENTS FOR SEIZURE DISORDERS

Please include the following in your narrative report.

1. Date(s) of your examination.
2. History obtained including:
  - a. Frequency of major and/or minor seizures.
  - b. Date of onset, diurnal or nocturnal attacks.
  - c. Description of a typical seizure to include:
    - 1) Presence of aura.
    - 2) Actual seizure manifestations (e.g., tongue bites, sphincter control, injuries incurred during attacks, etc.)
    - 3) Length of seizure.
    - 4) Postictal manifestations.
    - 5) Identify informant if other than client.
  - d. Previous treatment, including date started, type and dosage of medication and facts on whether client follows treatment (**explain**).
  - e. Presence of alcohol or drug usage, and amount.
  - f. Other relevant history.
  - g. Typical daily activities.
3. Findings on this examination including:
  - a. Height and weight (**without shoes**), blood pressure and pulse rate.
  - b. Positive and pertinent negative findings including:
    - 1) Site and description of motor weakness (1-5 with 5 normal) atrophy, sensory changes, reflex changes, cranial nerve deficits, tremor, rigidity, bradykinesia.
    - 2) Description of the effect of the above on gait and station, hand and finger dexterity.
    - 3) Description and assessment of the severity of any speech disturbance, including aphasia.
    - 4) Evidence of organic mental dysfunction.
    - 5) Description of any personality changes (e.g., appearance, thought content, affect).
4. Results and interpretation of laboratory findings.
5. Diagnosis and Prognosis.
6. Recommended treatment.
7. Describe any other significant condition present.

## REPORTING REQUIREMENTS FOR PSYCHIATRIC CONSULTATIVE EXAMINATIONS

Your report must include **all** of the elements listed below. Please address your report to the concepts described in DSM 111-R (i.e., your diagnosis should be supported by DSM JII-R terminology).

1. Date(s) of interview(s).
- 2- Self-sufficiency in coming to the examination including whether alone or by whom accompanied, distance and mode of travel, etc.
3. Longitudinal Psychiatric History including detailed discussion of complaints as well as past and present treatment.
  - a. Relevant features of personal, social, familial, marital, educational, military, medical and vocational elements of a psychiatric history should be included.
  - b. With respect to the vocational history, please provide complete details concerning client's adaptation on all jobs in the recent past (one or two years). Also, does the client believe him/herself unable to work and if so, why? (See 5c below.)
4. Full and Complete Description of Mental Status including examples of pathologic findings and verbatim statements where Indicated.
  - a. General appearance, attitude and behavior (e.g., dress, hygiene, mannerisms, movements, responsiveness, manner of relating, etc.)
  - b. Characteristics of Speech (e.g., relevance, coherence, associations, etc.)
  - c. Characteristics of Thought (e.g., delusions, hallucinations, obsessions, compulsions, phobias, preoccupations, etc.)
  - d. Mood and Affect (e.g., depth, broadness, appropriateness, etc.). Use of one word descriptions regarding mood or affect such as "distressed", "anxious", "tense" are not sufficient and should be amplified.
  - e. Sensorium and Intellectual Functions (e.g., orientation, memory, attention and concentration, information, serial sevens, calculations, etc.)
  - f. Insight and Judgment (e.g., self-assessment, plans for the future, etc.)
5. Functional Description and Assessment
  - a. Client's description of his or her mode of living, specifically with regard to daily activities, socialization, interests, capacity to care for his or her personal needs, perform household chores, shop, etc.
  - b. Your opinion regarding the consistency of allegations with your findings (Item 4) and resultant capacities (or limitations) in personal and social adjustment.
  - c. Your opinion regarding the consistency of vocational history (Item 3b) and the mental status examination.
6. Diagnosis: APA terminology per DSM 111-R (Axis I and II).
- 7 Suggested Therapy and Prognosis: Describe the duration of the impairment and the degree of improvement to be reasonably expected in: the near future.
8. Your opinion of the client's ability to manage his or her own funds. If not able to manage funds, please stat the reason for your opinion.

## REPORTING REQUIREMENTS FOR NEOPLASTIC DISEASES

Please include the following in your narrative report:

1. Date(s) of your examination.
2. History obtained including:
  - a. Description of present symptoms (i.e., general weakness, weight loss, nausea, vomiting, diarrhea, reactive mental disorders).
  - b. Date(s) and reason(s) for past hospitalization(s) especially related to the neoplastic condition.
  - c. Treatment given (i.e., surgery, radiotherapy, chemotherapy, hormonal therapy, etc.) with dates.
  - d. Other relevant history.
  - e. Typical daily activities.
3. Findings of this examination including:
  - a. Height and weight (**without shoes**), blood pressure and pulse rate.
  - b. Describe any significant post-therapeutic residuals, local or distant metastases.
  - c. Describe status of any external diversionary stomas present.
4. Results and interpretation of laboratory findings.
5. Complete diagnosis and prognosis.
6. Recommended treatment, if any.
7. Describe any other significant condition present.

## REPORTING REQUIREMENTS FOR INTELLIGENCE TESTING (ADULTS/CHILDREN)

- A. Please administer one of the preferred tests below for adults/children whose principal language is English. The most recent edition is preferred. The examining consultant must determine that the individual's fluency in English is sufficient to permit a valid assessment. If not fluent in English or non-verbal, see Section B. Use of an interpreter to administer the test is not acceptable unless authorized by our office.

WAIS (adults), WISC (6-16 yrs. 11 mos.), WPPSI (3-7 yrs.) - Most Recent Edition

If the above criteria cannot be fulfilled, provide the reason in your report and administer one of the other acceptable tests listed; Stanford-Binet, 3rd edition (2 yrs-16 yrs.) and 4th ed. (4 yrs. - 16 yrs.), Bayley Scales of Infant Development 2<sup>nd</sup> ed. (1 mo. - 42 mos.), Gesell Developmental Schedules (4 wks. - 6 yrs.), McCarthy Scales of Children's Abilities (2.5 yrs. - 8.5 yrs.).

- B. Administer the Raven Progressive Matrices, Leiter International Performance Scales/Leiter-R or TONI-2, when the client is non-verbal, has an organic or psychogenic language impairment or is not fluent in English; indicate reason non-verbal test was administered.
- C. Tests Not to be Administered: General Aptitude Test Battery, Adaptive Behavior Scale, Slosson Intelligence Test, EIWA, EIWN, EIWN-R and group or screening tests.
- D. Do not test anyone under the influence of any substance that would affect test validity.
- E. Include the following elements in your typed narrative report:
1. Date and name of test administered including a statement regarding client's principal language and fluency in English.
  2. History including medical, educational, social and daily activities.
  3. Self-sufficiency of the client in coming to the examination, appearance, mannerisms, and behavior during the examination.
  4. Full scale Performance and Verbal IQ scores together with all the individual subtest scores, including interpretation of the scores and assessment of the validity of the obtained scores, indicating any factors that may have influenced the results, e.g., cooperation, attitude, presence of visual, hearing or other physical problems, and recent prior exposure to the same or similar test.
  5. Based upon your observations during the administration of the 1.0. test, please give:
    - a. General impressions of the client's abilities, as appropriate for age, in attention and concentration, following simple directions: reading, writing, performing simple calculations, and conversation including speech and language development.
    - b. Description of client's self-sufficiency with respect to personal and social competence.
  6. A statement regarding the consistency of the obtained results with the client's education, vocational background (adults), social adjustment and personal self-sufficiency.
  7. Diagnosis: Current APA terminology.
  8. Prognosis: Probable duration and expected results of any recommended treatment.
  9. Your opinion whether the client (adults) is capable of managing benefit payments in his or her own interest. If not able to manage funds, please state the reason for your opinion.

**SOCIAL AND OCCUPATIONAL ASSESSMENT FORM**

Client's Name: \_\_\_\_\_ Disability ID # (DIN) \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Module/Unit: \_\_\_\_\_

Please include the elements listed below in your report or respond directly on the form.

1. Describe how the client spends a typical day with specifics as to daily activities, socialization, interests, capacity to care for personal needs, perform household chores, shop, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Describe the circumstances of any recent work attempts.

a. Job Title: \_\_\_\_\_

Dates of employment: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Any difficulties noted: \_\_\_\_\_

Was this a sheltered workshop?       Yes       No

If this job was terminated, why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

b. Job Title: \_\_\_\_\_

Dates of employment: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Any difficulties noted: \_\_\_\_\_

Was this a sheltered workshop?       Yes       No

If this job was terminated, why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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c. Job Title: \_\_\_\_\_

Dates of employment: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Any difficulties noted: \_\_\_\_\_

Was this a sheltered workshop?       Yes       No

If this job was terminated, why? \_\_\_\_\_

\_\_\_\_\_

3. Additional comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CHILDHOOD DISABILITY CONSULTATIVE EXAMINATION GENERAL QUESTIONNAIRE

**Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report.**

1. Date(s) of your examination.
2. History obtained including:
  - a. Informant.
  - b. Date(s) and description(s) of earliest symptoms.
  - c. Date(s) and reasons for any hospitalization(s), including name and location of hospital.
  - d. Nature of treatment given with type of medication, dose and response if known to informant.
  - e. Other relevant history.
3. Diagnosis, including etiology and basis for your conclusion.
4. Findings on this examination including:
  - a. Height and weight (**without shoes**).
  - b. Blood pressure, pulse and respiration rate.
  - c. Other pertinent findings (attached form(s) give(s) specifics in question 7).
  - d. Results and interpretation of any laboratory studies requested.
5. Please indicate if the child's function/behavior is age appropriate. If no, please describe and note the age at which the child does function regarding the following:
  - a. fine/gross motor skills
  - b. sensory abilities
  - c. communication skills
  - d. cognitive skills
  - e. social/emotional skills
6. Please describe how activities (e.g., ability to go to school, dress, play, feed, etc.) are affected by the impairment.

### CHILDHOOD GROWTH IMPAIRMENT

**Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report.**

7. Physical findings should include funduscopic, neurological findings, etc.
8. Give the following related to growth retardation:
  - a. Child's length at birth.
  - b. Three subsequent heights and weights with dates obtained (if available).
  - c. Heights of natural parents
  - d. Heights and ages of siblings.
9. If bone age determination has been requested by our office, it should include a full descriptive x-ray report citing the standardization method used, x-ray taken should include left hand and wrist. In a child at or past puberty, x-ray of left knee and ankle should also be included. If bone age is retarded, express results in terms of number of standard deviation (SD) below the mean for chronological age.



## CHILDHOOD MUSCULOSKELETAL IMPAIRMENT

**Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report.**

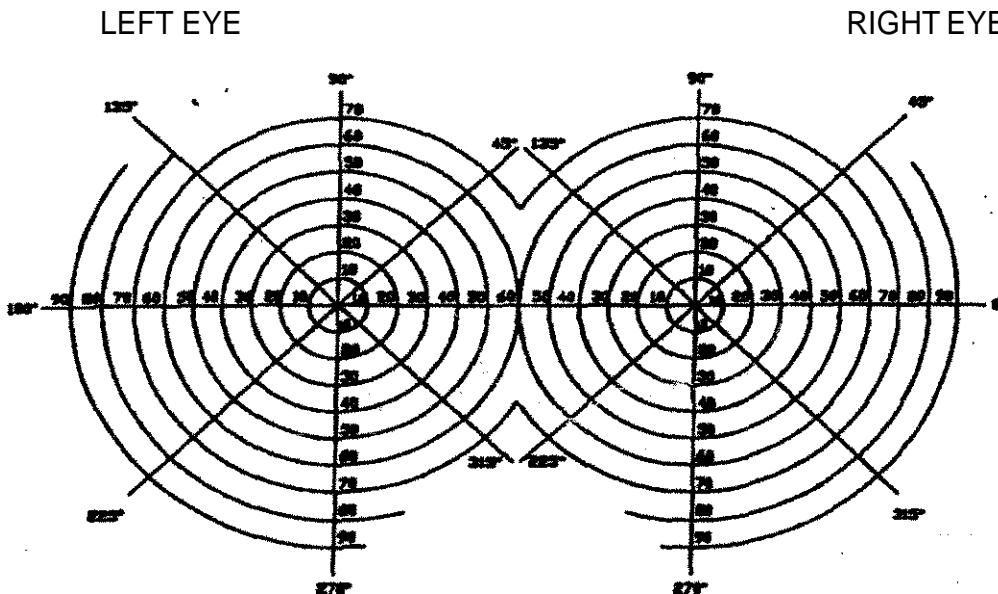
7. Physical examination should include:
  - a. All joints or area of spine involved.
  - b. Remaining degrees of motion in the involved joints or spine.
  - c. Other abnormal findings including abnormal neurological findings, contractures or amputations.
  - d. In cases involving spinal abnormalities (e.g., Kyphosis, Lordosis, Scoliosis, etc.) please describe major spinal curve in degrees.
  - e. In cases involving rheumatoid arthritis, please note presence of joint swelling, tenderness or inflammation, systemic involvement, etc.
8. Description of treatment and response should note persistence or recurrence of joint inflammation in rheumatoid arthritis cases and comment upon any evidence of steroid dependence.
9. Give ability to walk in terms of reduction in speed, distance able to travel with or without orthotic or prosthetic device, ability to ambulate without a walker or crutches.

CHILDHOOD VISUAL IMPAIRMENT

Client: \_\_\_\_\_ Disability ID # (DIN): \_\_\_\_\_ Mod/Unit: \_\_\_\_\_

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report.

7. Describe any ocular pathology present including a description of the external eye and findings on ophthalmoscopy, slit-lamp examination, etc.
8. If bilateral cataracts are present, please give severity in terms of fundus visualization.
9. Note presence or absence of the accommodative reflex.
10. Give central visual acuity with best corrections for each eye. Indicate technique used for ascertaining central visual acuity for distance (e.g., standard Snellen Chart, free standing E's, etc.) and reason technique was selected.
11. Complete the fields of vision chart which follows using the appropriate test object(s) as shown below. This chart must be completed even when the field is zero.



Please check the appropriate box(es) to show the test object(s) used:

- 3mm/330mm white                       aphakia 6mm/330 white
- scotomata: 2mm/1000mm white with corrective lenses

12. If visual acuity or fields cannot be precisely measured, please describe ability to perceive light, hand movements, colored objects and probable constriction of fields.

PHYSICIAN'S SIGNATURE

DATE

X \_\_\_\_\_

\_\_\_\_\_

## CHILDHOOD HEARING IMPAIRMENT

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report.

7. Physical findings should include any pathology noted on physical examination.
8. Describe effect of hearing impairment upon speech. (If speech is affected, describe in terms of clarity and content).
9. Results of audiometric testing including (without hearing aids):
  - a. Results in decibels at each of the following frequencies:  

(1) 500HZ	(2) 1000HZ	(3) 2000HZ	(4) 4000HZ
-----------	------------	------------	------------
  - b. Average hearing levels of the four frequencies in: (1) Right Ear (2) Left Ear
  - c. Type of audiometer used – if not standard, explain why.
  - d. Type of calibration used (ANSI-1969 or ASA-1951).
10. Additional testing with no cochlear implant
  - a. Speech reception threshold (SRT) testing (also referred to as "spondee threshold" or "ST" testing), and word recognition testing (also referred to as "word discrimination" or "speech discrimination" testing). This testing must be conducted in a sound-treated booth or room and must be in accordance with the most recently published standards of the American National Standards Institute (ANSI). Each ear must be tested separately and hearing aids must not be worn during the testing.
    - i. The SRT is the minimum dB level required to recognize 50 percent of the words on a standard list of spondee words. (Spondee words are two-syllable words that have equal stress on each syllable.) The SRT is usually within 10 dB of the average pure tone air conduction hearing thresholds at 500, 1000, and 2000Hz. If the SRT is not within 10 dB of the average pure tone air conduction threshold, the reason for the discrepancy must be documented.
    - ii. Word recognition testing determines ability to recognize an age-appropriate, standardized list of phonetically balanced monosyllabic words in the absence of any visual cues. This testing must be performed in quiet. The list may be recorded or presented live, but in either case, the words should be presented at a level of amplification that will measure maximum ability to discriminate words, usually 35 to 40 dB above your SRT. However, the amplification level used in the testing must be medically appropriate, and the individual must be able to tolerate it. If the individual cannot be tested at 35 to 40 dB above SRT, the person who performs the test should report word recognition testing score at the highest comfortable level of amplification.
11. Additional testing with cochlear implant
  - a. Word recognition testing performed with any age-appropriate version of the Hearing in Noise Test (HINT) or the Hearing in Noise Test for Children (HINT-C). This testing must be conducted in quiet in a sound field. The implant must be functioning properly and adjusted to the individual's normal settings. The sentences should be presented at 60 dB HL (Hearing Level) and without any visual cues.

### CHILDHOOD RESPIRATORY IMPAIRMENT

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report.

7. Physical findings should note presence of wheezing, cyanosis, etc.
8. If child is short for age, give the following:
  - a. Child's length at birth.
  - b. Three subsequent heights and weights with dates obtained (if available).
  - c. Heights of natural parents.
  - d. Heights and ages of siblings.
9. In cases involving bronchial asthma, include dates of any recurrent intense attacks within the past six months which required parenteral medication.
10. In cases involving cystic fibrosis, document any history of:
  - a. Dyspnea on mild exertion.
  - b. Chronic, frequent, productive cough.

### CHILDHOOD CARDIOVASCULAR IMPAIRMENT

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report.

7. Physical findings on examination should include:
  - a. Blood pressure readings for both upper and lower extremities, heart and respiration rates at rest. funduscopic findings.
  - b. Complete description of any murmurs, including location and intensity.
  - c. Description of any organ enlargement. If hepatomegaly is present, measure below the costal margin in mid-clavicular line should be given in centimeters.
8. If child is short for age, please give:
  - a. Length at birth.
  - b. Three subsequent heights and weights with dates obtained (if available).
  - c. Heights of natural parents.
  - d. Heights and ages of any siblings.
9. Note any:
  - a. Episodes of acute illness.
  - b. Signs and symptoms of cardiac disease such as cyanosis, syncope, squatting, etc.
  - c. Signs of fatigability or exercise intolerance (or, in infants, difficulty in feeding).

CHILDHOOD DIGESTIVE IMPAIRMENT

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report:

7. If child is short for age, please give:
  - a. Length at birth.
  - b. Three subsequent heights and weights with dates obtained (if available).
  - c. Heights of natural parents.
  - d. Heights and ages of any siblings.
8. Document any weight losses, previous weights.
9. Your prognosis and recommendations for further treatment.

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CHILDHOOD GENITO-URINARY IMPAIRMENT

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report:

7. Findings on physical examination should include funduscopy, etc.
8. If a child is short for age, please include:
  - a. Length at birth.
  - b. Three subsequent heights and weights with dates obtained (if available).
  - c. Heights of natural parents.
  - d. Heights and ages of siblings.
9. Elicit frequency of renal infections.
10. Give your prognosis including recommended treatment, expected result, time needed to achieve that result.

### CHILDHOOD HEMIC & LYMPHATIC IMPAIRMENT

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report:

7. Physical findings should include all abnormalities noted in the various body systems.
8. If child is short for age, please include:
  - a. Length at birth.
  - b. Three subsequent heights and weights with dates obtained (if available).
  - c. Heights of natural parents.
  - d. Heights and ages of any siblings.
9. In cases of idiopathic thrombocytopenic purpura coagulation disorder, give:
  - a. Episodes of repeated spontaneous or inappropriate bleeding.
  - b. Sites of bleeding.
  - c. Severity of bleeding.
10. In cases of sickle cell disease, give major visceral episodes within 1 year of your exam with dates (e.g., meningitis, osteomyelitis, pulmonary infections, cerebrovascular accidents, congestive heart failure, genito-urinary involvement, hyperhemolytic, aplastic or vaso-occlusive crises). Give severity and duration.



### CHILDHOOD ENDOCRINE IMPAIRMENT

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report:

7. Physical findings should include funduscopy and neurological findings, etc.
8. History should include dates and duration of any episodes of tetany, convulsion, hypernatremia, circulatory collapse, hypoglycemia or coma.
9. Give the following related to growth impairment:
  - a. Length at birth.
  - b. Three subsequent heights and weights with dates obtained (if available).
  - c. Heights of natural parents.
  - d. Heights and ages of any siblings.
10. If bone age determination has been requested by this office, it should include a full, descriptive x-ray report citing the standardization method used. X-ray taken should include left hand and wrist. In a child at or past puberty, x-ray of knee and ankle should also be included. If bone age is retarded, express results in number of standard deviations (SD) below the mean for chronological age.

## CHILDHOOD NEUROLOGICAL IMPAIRMENT

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report:

- 7 Describe complete neurological status. In cases involving seizure disorders include:
  - a. Severity of any speech, visual or hearing disorder.
  - b. Describe any emotional disorder and assess its severity.
  - c. Any physical evidence of a seizure disorder.
  - d. Significant adverse effects, if any, from present medication.
8. Description of any seizure disorder (e.g., major, minor, diurnal or nocturnal, grand or petit mal, etc.) with frequency, date of last episode, residuals.  
  
Please elicit a description of a typical seizure, and indicate who witnessed it.
9. What are your recommendations for treatment and management; what results can be expected?

REPORTING REQUIREMENTS FOR CHILD/ADOLESCENT PSYCHIATRIC  
CONSULTATIVE EXAMINATIONS

Your typed narrative report must include all of the elements listed below. Please address your report to the concepts described in DSM III-R (i.e. your diagnoses should be supported by DSM III-R terminology).

1. Date(s) of interview(s).
2. Who accompanied child/adolescent to the examination, distance, mode of travel, etc.
3. Source of information (relationship to child/adolescent).
4. Longitudinal psychiatric history including detailed discussion of complaints and behavior as well as past and present treatment and response.
  - a. Hospitalizations (medical and psychiatric)
  - b. Familial (parents, foster care, etc.)
  - c. Relationship with parents (and other adults/authority figures)
  - d. Relationship with peers (friends, prefers younger or older children)
  - e. Educational (performance in school, special ed., multiple school changes, etc.)
  - f. Hobbies and interests
  - g. Any other relevant factors
5. Complete mental status examination including examples of pathologic findings and verbatim statements where indicated.
  - a. General appearance, attitude and behavior (e.g., dress, hygiene, mannerisms, movements, responsiveness, manner of relating, etc.).
  - b. Characteristics of Speech (e.g., intelligibility, age appropriateness, etc.).
  - c. Characteristics of Thought (preoccupations, delusions, hallucinations, suicidal, etc.).
  - d. Mood and Affect (e.g., depth, broadness, appropriateness, etc.). Use of one word descriptions regarding mood or affect for example "happy", "depressed", "tense" are not sufficient and should be amplified.
  - e. Memory, Attention, Concentration and Information (age appropriate).
  - f. Insight and judgment (age appropriate).
6. Functional Description and Assessment
  - a. Client's description of age appropriate daily activities, attending school, socialization, hobbies, interests, sports, chores, etc.
  - b. Briefly summarize how your observations and examination of this child/adolescent coincide with the chief complaint(s) and the ability to function in an age appropriate manner (e.g., socially/emotionally, cognitively and communicatively).
7. Diagnosis: APA terminology per DSM III-R Axis I & II (and Axis III where relevant).
8. Prognosis and suggested therapy: describe the duration of the impairment and the degree of improvement to be reasonably expected in the near future.

CHILDHOOD NEOPLASTIC DISEASE

Please provide information regarding the applicable items on this and the attached questionnaire(s) in your typed narrative report:

7. Physical examination should include:
  - a. Size and extent of tumor(s), if present.
  - b. Any evidence of distant metastases.
  - c. In cases of neuroblastoma, any extension across the mid-line noted.
  - d. In cases of retinoblastoma, any evidence of bilateral involvement.
  - e. Post therapeutic residuals.
8. History should include:
  - a. Basis on which diagnosis was made (biopsy, x-rays, surgery, etc.).
  - b. Any recurrence, with dates, if known, and how established.

## REPORTING REQUIREMENTS FOR DA/A MEDICAL EVALUATION BY INTERNIST

Please include the following in your narrative report:

1. Date(s) of your examination.
2. History obtained including:
  - a. Chief Complaint(s).
  - b. Date(s) drug/alcohol usage began, addictive drugs used, and extent of drugs.
  - c. Date(s) and reason(s) for any hospitalization(s).
  - d. Nature of treatment given with type of medication, dosage and frequency, if known, and response.
  - e. Other relevant history, including vocational history.
  - f. Typical daily activities and social interactions.
3. Findings on this examination including:
  - a. Height and weight (without shoes), pulse rate, blood pressure, and general appearance and behavior.
  - b. Vision (with best correction) and retinal findings.
  - c. Physical findings, including pertinent neurological signs and symptoms.
4. Results and interpretation of laboratory findings.
5. Based upon history, examination findings, and observation, identify whether client exhibited any significant mental findings (describe).
6. Diagnosis with prognosis.