

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MEDICAL REVIEW TEAM (MRT)

General Physical (Adults)

This report **may** be made available to the patient or representative upon request.

MA ID/Pending Medicaid #: _____ Requesting DHHR Office: _____

PATIENT: _____ SSN: _____
Last First Middle

Date of Birth: _____ Sex: Male Female

Customary Occupation: _____

If currently under a physician's care, give name of physician and reason for care: _____

Date Referred: _____ Return To: WV DHHR, _____ County Office

PHYSICAL EXAMINATION (Must be completed in full)

A. Applicant's Statement of Incapacity / Disability: _____

B. Measurements and Findings:

Height: _____	Weight: _____	Distant Vision Without Glasses:
Temp.: _____	Pulse: _____	R Eye: 20/ _____ L Eye: 20/ _____
BP: Systolic: _____	Diastolic: _____	Distant Vision With Glasses:
Speech: _____		R Eye: 20/ _____ L Eye: 20/ _____
Posture: _____		Eyes: Other than Vision: _____
Gait: _____		Ears: Right _____ Left _____
		Ears: Other than Hearing _____

C. After examination, check if NORMAL and comment if findings are ABNORMAL:

- 1. Mouth and Teeth _____
- 2. Nose and Throat _____
- 3. Neck _____
- 4. Lymphatic system _____
- 5. Breasts _____
- 6. Lungs and Chest _____
- 7. Heart _____
- 8. Abdomen _____
- 9. Hernia Type: _____ Reducible: Yes No
- 10. Varicose Veins _____
- 11. Edema (sites) _____
- 12. Neurological _____
- 13. Psychiatric _____
- 14. Orthopedic _____
- 15. Arteriosclerosis _____
- 16. Genito-Urinary _____
- 17. Gynecological _____
- 18. Ano-rectal _____

D. Describe in detail any pain: _____

E. Diagnosis: Major: _____ Minor: _____

F. Applicant's Ability to Work Full-Time:

1. Is applicant able to work full-time at customary occupation or like work: Yes No
Explain: _____

2. Is applicant able to perform other full time work: Yes No
Explain: _____

3. What work situations, if any, should be avoided: _____

4. Duration of inability to work full time: One month Six months One year
 Other Explain: _____

G. Recommendations for further tests or treatment:

1. Diagnostic Tests: _____

2. Specialist's Consultations: _____

3. Treatment (Specify Type): _____

H. Should applicant be referred for **vocational rehabilitation?** Yes No

I. Summary of Conclusions: _____

Date of Examination

Examining Physician's Signature

Printed Name of Physician