SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB NO. 0960-0102

DATE OF THIS REQUEST

# MEDICAL REPORT
## *(Individual with Childhood Impairment)*

**NOTICE TO PHYSICIAN: Please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable a reviewing physician to make an independent determination as to the onset, severity and duration of the impairment.**

(d) →

**PRIVACY ACT:** The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i) and 1631(~~e~~)(1) of the Social Security Act. The information on this form is needed by Social Security to complete processing of the named patient's claim. While giving us the information on this form is voluntary, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim. Although the information you furnish on this form is almost never used for any purpose other than making a determination about disability, such information may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange of information between Social Security and another agency.

**Computer Matching Statement:** We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

**Paperwork Reduction Act -** This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. SEND THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not have that address, you may call Social Security at 1-800-772-1213. *You may send comments on our time estimate above to:* ***SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.***

| | | | |
|---|---|---|---|
| IDENTIFYING INFORMATION (To be completed by requesting office) | PATIENT'S NAME | DATE OF BIRTH | WAGE EARNER'S SSN<br>– – |
| | WAGE EARNER'S NAME | NAME AND ADDRESS OF REQUESTING OFFICE | |

I. HISTORY AND FINDINGS (Give clinical course, including therapy and response.)

II. DIAGNOSES:

1.

2.

3.

| DATE IMPAIRMENT BEGAN | DATE YOU FIRST EXAMINED PATIENT | DATE OF LAST EXAMINATION | HEIGHT | WEIGHT |
|---|---|---|---|---|
| | | | | |

III. Give dates and results of laboratory or other tests or studies administered by you or reflected in your records.

IV. If the condition relates to mental deficiency or illness, personality, emotional or nervous disorders, please complete A and B (below), give the results of psychometric tests administered, when administered, and give any I.Q. data you have.

A. Comment on the patient's ability to follow instructions, travel, get along with others and otherwise conform to a job-related setting.

B. In your opinion, is the patient able to manage his/her own funds? ☐ YES ☐ NO (Explain)

| REPORTING PHYSICIAN'S NAME AND ADDRESS | SIGNATURE | TITLE |
|---|---|---|
| Medical Sources | TELEPHONE NUMBER (*Include area code*) | DATE |