



IAPPEALS REVITALIZATION

EDCS 3441 SCREEN MOCK-UPS

VERSION 4.0

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1. Screen Designs

1.1. 3441 About You

3441 About You

Identification

Name: John Q. Public
Daytime telephone number: 555-555-5555
Alternate telephone number is: U.S. Foreign None
Alternate telephone number: (999-999-9999) **Ext:**
E-mail address:

Other Names Used

Have you used any other names on your medical or educational records?
Examples are maiden name, other married name, or nickname

Yes No Not yet answered

[Hide information from prior level\(s\)](#)

Prior names available for copying:
To copy a name from a prior level, select the name below.

The names listed below were either added or updated at the level shown.

Other Names	Level
public, j.q.	RC
public, john quincy	RC

To add a name, choose Add Other Name. To edit, select the name below.

Other Names

[Public, Jack Q.](#)

1.2. 3441 Contacts

3441 Contacts

Alternate Contact Information

Is there someone (other than your doctors) we can contact who knows about your medical conditions and can help you with your case?

Yes No Not yet answered

Name of Alternate Contact

*First name: Middle name: *Last name: Suffix:

Relationship to disabled person:

Address for Alternate Contact

Address is: U.S. Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City: State: ZIP Code:

Telephone for Alternate Contact

Telephone number is: U.S. Foreign None

Daytime telephone number: (999-999-9999) Ext:

Preferred Language for Alternate Contact

Can this person speak and understand English?

Yes No Not yet answered

If "NO", what language is preferred?

Person Completing the Report

*Who is providing information?

John Q. Public

Alternate Contact listed above

Someone else

Name of Person Completing This Report

First name: Middle name: Last name: Suffix:

Agency name:

Relationship to disabled person:

Address for Person Completing This Report

Address is: U.S. Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City: State: ZIP Code:


Telephone for Person Completing This Report

Telephone number is: U.S. Foreign None

Daytime telephone number: (999-999-9999) Ext:

1.3. 3441 Medical Conditions

3441 Medical Conditions

Date of last disability report (MM/DD/YYYY): 

Medical Conditions

When you filed your claim you told us that your physical or mental conditions included:

Severe depression and anxiety take medication daily for it; ANXIETY;

* Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your physical or mental conditions?

Yes No Not yet answered

Please describe in detail:

[Examples of changes in conditions](#)

Anxiety is more frequent.

Approximate date the change(s) occurred:

If you can't remember the exact dates, be as specific as possible.

Examples:

- June 11, 2002
- October 2000
- Summer 1999

* Since you last told us about your medical conditions, do you have any NEW physical or mental conditions?

Include:

- New impairments that started since you filed your claim
- Impairments you forgot to tell us about when you applied

Yes No Not yet answered

Please describe in detail:

[Examples of new conditions](#)

Difficulty in getting enough sleep.

Approximate beginning date:

If you can't remember the exact dates, be as specific as possible.

Examples:

- June 11, 2002
- October 2000
- Summer 1999

1.4. 3441 Medical Sources

3441 Medical Sources

Doctors, HMOs, Therapists, Hospitals, Clinics

Since you last told us about your medical treatment, have you seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled?

Yes No Not yet answered

What type(s) of condition(s) were you treated for, or will you be seen for?

Physical Mental (including emotional or learning problems)

[Hide information from prior level\(s\)](#)

Prior medical sources available for copying:

To copy a medical source from a prior level, select the medical source name below.

The sources listed below were either added or updated at the level shown.

Name	Date last seen	Level
ECHN	none	RC
KELTON, JESSICA L LCSW	* 5-5-2011	RC
LEGARE, KATHI LCSW, CHILD, ADOLESCENT & FAMILY THERAPIST	OCTOBER 12, 2010	IN
lowney, donna Dr., WOMENS WELLNESS CENTER	SUMMER07	IN

Tell us who may have NEW medical records about any of your physical or mental conditions (including emotional or learning problems). Please include doctors' offices, hospitals (including emergency room visits), clinics, mental health centers and other healthcare facilities.

Only list the providers you have seen since you last told us about your medical treatment.

Include:

- All types of providers (physicians, psychologists, optometrists, nurse practitioners, therapists, chiropractors, acupuncturists, etc.)
- Places where you had treatments, tests, surgery, or emergency room visits

To add a medical care provider, choose Add Doctor/Hospital/Etc. To edit, select the name below.

Name	Address
bayona, garald Dr., TOLLAND INTERNAL MEDICAN	MARROW RD
CONNECTICUT BEHAVIORAL HEALTH	* 4 WEST ROAD
John Hopkins Bayview Medical Center	4940 Eastern Ave
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	* MEDICAL RECORDS DEPARTMENT

Add Doctor/Hospital/Etc.

1.5. Doctor/HMO/Therapist Information

Doctor/HMO/Therapist Information

Name: [ALEXANDER BLAIR SMITH MD](#)

Attention:

Address: CORP CARE OCCUPATIONAL HEALTH

Patient ID# (if known):

Dates

If you can't remember the exact dates, be as specific as possible.
Examples:

- June 11, 2002
- October 2000
- Summer 1999

First visit:

Previous last visit:

Last visit:

Next appointment:

Conditions and Treatments

What medical conditions were treated or evaluated?
Examples:

- To get my blood monitored
- I had a seizure
- I developed an infection

What treatment did you receive for the above conditions?
Examples:

- Physical therapy
- Counseling
- Heat treatments
- Medicines

Tests

List any tests this provider performed, sent you to, or scheduled you to take in the future.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By
------	------	------------

Medicines

List all medicines you are taking that were prescribed or suggested by this provider.

To add a medicine, choose Add Medicine. To edit, select the medicine below.

Medicine	Prescribed By	Reason
----------	---------------	--------

1.6. Hospital/Clinic Information

Hospital/Clinic Information

Name of facility or office: [JOHNS HOPKINS BAYVIEW MEDICAL CENTER](#)

Attention:
Address: MEDICAL RECORDS DEPARTMENT

Health care professional who treated you at JOHNS HOPKINS BAYVIEW MEDICAL CENTER:

Patient ID# (if known):

Dates at this Facility

Enter dates for all types of visits that apply. If you can't remember the exact dates, be as specific as possible. Dates must include a year.
Examples:

- June 11, 2002
- October 2000
- Summer 1999

Did you have any inpatient stays?
If more than three, give the most recent ones.
 Yes No Not yet answered

Date in: Date out:
Date in: Date out:
Date in: Date out:

Did you have any outpatient visits? Yes No Not yet answered

First visit:
Last visit:
Next appointment:

Did you have emergency room visits?
If more than three, give the most recent ones.
 Yes No Not yet answered

Date of visit:
Date of visit:
Date of visit:

Conditions and Treatments

What medical conditions were treated or evaluated?
Examples:

- To get my blood monitored
- I had a seizure
- I fell off a ladder at work

What treatment did you receive for the above conditions?
Examples:

- Physical therapy at the Rehab Clinic
- Blood transfusion
- Surgery
- Chemotherapy at the Oncology Clinic
- Stitches

(For outpatient care, include the location within the hospital if possible.)

Tests

List any tests this provider performed, sent you to, or scheduled you to take in the future.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By
------	------	------------

Medicines

List all medicines you are taking that were prescribed or suggested by this provider.

To add a medicine, choose Add Medicine. To edit, select the name of the medicine below.

Medicine	Prescribed By	Reason
----------	---------------	--------

1.7. 3441 Other Medical Information

3441 Other Medical Information

Since you last told us about your other medical information, does anyone else have medical information about your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else?

Examples:

- Worker's Compensation
- Vocational rehabilitation services
- Insurance companies who have paid you disability benefits
- Prisons and correctional facilities
- Attorneys
- Social service agencies
- Welfare agencies
- School/education records

Yes No Not yet answered

There is no information of this type in prior level(s).

List any other people or places that may have your medical information or records since you last told us about your other medical information.

To add a medical source, choose Add Source. To edit, select the name below.

Name	Address

Add Source

1.8. Other Medical Information Detail

Other Medical Information Detail

Name:

Attention:

Address: 719 BIRDSEYE STREET

Claim or ID Number, if any:

Dates

If you can't remember the exact dates, be as specific as possible.

Examples:

- June 11, 2002
- October 2000
- Summer 1999

Date of first contact:

Date of last contact:

Date of next contact, if any:

Reasons for Contacts

Reasons for contacts:

1.9. 3441 Medicines Summary

3441 Medicines Summary

Are you currently taking any medicines (prescription or non-prescription)?

Yes No Not yet answered

[Hide information from prior level\(s\)](#)

Prior medicines available for copying:

To copy a medicine from a prior level, select the medicine below.

The medicine(s) listed below were either added or updated at the level shown.

Medicine	Prescribed by	Reason	Level
albuteral inhaler	bayona, garakd Dr., TOLLAND INTERNAL MEDICAN	asthma	RC
extra strength tyloanal 2-3 ti	myself, myself Ms., none	my body huts u dont know if its the depression or something else but my body just is pain everyday.	RC
paxil 30mg daily	shahab, EURM Dr., ELLINGTON BEHAVIRAL HEALTH	depression and anxiety	RC

List all prescription and non-prescription medicines that you are currently taking for your condition.

To add a medicine, choose Add Medication. To edit, select the medicine listed below.

Medicine	Prescribed by	Reason
ABILFY	SHAHAB, ERUM MD	ANXIETY
Actos	*No Source*	*No Reason*

Add Medication

1.10. Medicine Information

Medicine Information

*Name of medicine:

Who prescribed this medicine (if prescription)?
If you need to add a medical source, you must return to the Medical Sources page.

Reason for medicine:
Examples:

- Slows down my heart rate
- Regulates my blood sugar
- Stops the pain

What side effects have you experienced?
Include physical and mental effects and/or allergic reactions that may affect your ability to work.
Examples:

- Makes me so tired I can't do anything
- Makes me sick to my stomach
- Causes diarrhea

1.11. 3441 Tests Summary

3441 Tests Summary

Since you last told us about your tests, have you had any medical tests or do you have any tests scheduled in the future?

Yes No Not yet answered

There is no information of this type in prior level(s).

List all tests that you had or are scheduled to have since you last told us about your tests.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By
Biopsy (right knee)		*No Source*
ct scan (left knee)		*Unknown*

Add Test

1.12. 3441 Activities

3441 Activities

Information About Your Activities

Since you last told us about your activities, has there been any change (for better or worse) in your daily activities due to your physical or mental conditions?

Examples:

- Household tasks
- Personal care
- Getting around
- Hobbies and interests
- Social activities

Yes No Not yet answered

Describe in detail.

1.13. 3441 Work and Education

3441 Work and Education

Work Information

Since you last told us about your work, have you worked or has your work changed?

If yes, you will be asked to provide additional information.

Yes No Not yet answered

Education Information

Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?

Yes No Not yet answered

Describe what type:

Date(s) attended:

1.14. Test Information

Test Information

Name of test:
[Description of tests](#)
 ...

Date of test:
If you can't remember the exact dates, be as specific as possible. Examples:

- 10/13/2002
- June 2001

Provider who performed, sent you to, or scheduled you to take this test.
If you need to add a medical source, you must return to the [Medical Sources page](#).

I have had this test more than once.

1.15. 3441 Vocational Rehabilitation, Employment, or Other Support Services

3441 Vocational Rehabilitation, Employment, or Other Support Services

Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- An individualized education program (IEP) through an educational institution (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

Yes No Not yet answered

There is no information of this type in prior level(s).

List all plans or programs attended since you last told us about your vocational rehabilitation.

To add a plan or program, choose Add a Plan or Program. To edit, select the plan or program name below.

Organization/School	Name of Counselor/Instructor
ABBOTT TERRACE HEALTH CENTER	* *No Counselor/Instructor name*
BACON ACADEMY	* *No Counselor/Instructor name*

Add a Plan or Program

1.16. Vocational Rehabilitation, Employment, or Other Services Information

Vocational Rehabilitation, Employment, or Other Services Information

Organization/School

Name: [ABBOTT TERRACE HEALTH CENTER](#)

Attention:

Address: 44 ABBOTT TERRACE

Dates Seen

If you can't remember the exact dates, be as specific as possible.

Examples:

- June 10, 2001
- February 1998
- Summer 1995

Date when you started participating in the plan or program:

1.17. 3441 Remarks

3441 Remarks

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about.



1.18. Screen Mock-up Version Information

<i>Version Number</i>	<i>Date</i>	<i>Content Revisions</i>	<i>Page #</i>	<i>Revised by</i>
1.0	2/28/14	Version 1.0		Beth Candella
2.0	3/5/14	Updated Section 1.15 Vocational Rehabilitation screen mock-up	17	Beth Candella
3.0	3/25/14	Updated Section 1.13 Work and Education screen mock-up with new wording per ODP	15	Beth Candella
4.0	3/27/14	Updated Section 1.15 Vocation Rehabilitation to remove "COMPLETE THIS SECTION..."	17	Beth Candella