United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0038

MEDICAL ASSESSMENT Proposed

SECTION 1 - Instructions

Some items on this form will not apply to you and you will not need to answer them. Based on your answer to a question, you may be told to skip to another item number, or even another section. Follow the instructions that tell you to "Go to" another item. These are designed to save you time and help you move through this Medical Assessment quickly, filling in only necessary information. If no "Go to" instructions are given, answer the next item in order. Do not skip any items unless directed to do so. Enter "NA" for not affected or "UNK" for unknown, as appropriate.

Please read the Important Notices on page 7.

SECTION 2 - Patient Identification

Railroad Retirement Claim Number	
Social Security Number	
Name	
Address	,
Telephone Number	( ) -

SECTION 3 - General Information

1	Enter the date you began treating the patient.	Month	Day	Year
2	Enter the date of the last examination.	Month	Day	Year
3	Enter the patient's weight and height.	_____ Weight _____ Height		

SECTION 4 - Musculoskeletal System

4	A	Enter an "X" in the appropriate box: Is the musculoskeletal system normal?	☐ YES - Go to Section 5 A ☐ NO - Go to Item 4B
	B	Describe the impairment. **Attach a copy of any x-ray reports, MRI reports, CT scan reports, etc.**	
5	A	Enter an "X" in the appropriate box: Is there a limitation of motion in the spine or any joints?	☐ YES - Check this box then go to Item 5B and enter either: • the range of motion or • an "N" for normal range of motion ☐ NO - Check this box then go to Item 6

5	B		Normal Degrees	Actual Degrees		Normal Degrees	Actual Degrees
		CERVICAL SPINE			**DORSOLUMBAR SPINE**		
		Flexion	45		Flexion	90	
		Extension	45		Extension	30	
		Right Lateral Flexion	45		Right Lateral Flexion	30	
		Left Lateral Flexion	45		Left Lateral Flexion	30	
		Right Rotation	60				
		Left Rotation	60				

		SHOULDER		Right	Left	**HIP**		Right	Left
		Abduction	150			Abduction	40		
		Forward Elevation	150			Adduction	20		
		Internal Rotation	80			Flexion	100		
		External Rotation	80			Extension	30		
		ELBOW				Internal Rotation	40		
		Flexion	150			External Rotation	50		
		Extension	0			**KNEE**			
		Supination	80			Flexion	150		
		Pronation	80			Extension	0		
		WRIST				**ANKLE**			
		Dorsi-Flexion	60			Dorsi-Flexion	20		
		Palmar-Flexion	70			Plantar-Flexion	40		

6	Enter an "X" in the appropriate box: Are there paraspinal muscle spasms present on examination?	☐ YES ☐ NO
7	Describe muscle strength on a graded scale. (0 to 5/5). Lower Extremity (Name left or right joint or muscle group and grade): Upper Extremity (Name left or right joint or muscle group and grade):	
8	Describe ~~any sensory or reflex abnormalities.~~ reflexes on a graded scale (0 to 4+) and describe any sensory abnormalities. Lower Extremity (Name left or right joint or muscle group and grade): Upper Extremity (Name left or right joint or muscle group and grade):	
9	A Describe, in detail, the patient's gait and station.	

9	B	Enter an "X" in the appropriate box: Does the patient walk with an assistive device?	☐ YES - Go to Item 9C ☐ NO - Go to Item 10
	C	How far can the patient walk without using an assistive device?	
10	A	Enter an "X" in the appropriate box: Are there any abnormalities in the patient's hands or fingers?	☐ YES - Go to Item 10B ☐ NO - Go to Section 5
	B	Describe any restrictions in the patient's ability to perform gross and fine manipulations. For example, can the patient pick up a pencil or turn a door knob, etc.? Quantify grip strength on a graded scale.	
SECTION 5 - Cardiovascular System			
11	A	Enter an "X" in the appropriate box: Is the cardiovascular system normal?	☐ YES - Go to Section 6 ☐ NO - Go to Item 11B
~~11~~	B	Describe the impairment. Provide any signs of decompensation (edema, cyanosis), etc. Describe any chest pains including character, location, radiation, frequency, duration, precipitating factors, relieving factors, and associated symptoms. **Attach a copy of any EKG tracings, x-ray reports, etc.**	
12		Describe any signs of congestive heart failure.	

13		Describe any rhythm disturbances.	
14		Describe any evidence of arterial or venous insufficiency (e.g., intermittent claudication, pulse deficits, brawny edema, etc.).	
SECTION 6 - Respiratory System			
15	A	Enter an "X" in the appropriate box: Is the respiratory system normal?	☐ YES - Go to Section 7 ☐ NO - Go to Item 15B
	B	Provide detailed objective findings. **Attach a copy of any pulmonary function test (including tracings), x-ray reports, or sputum culture results.**	
SECTION 7 - Neurological System			
16	A	Enter an "X" in the appropriate box: Is there a neurological impairment?	☐ YES - Go to Item 16B ☐ NO - Go to Section 8
	B	Describe, in detail, any abnormal neurological findings.	
17		Describe the character, the frequency of attack and the response to medication of any convulsive or seizure disorder.	
SECTION 8 - Vision/Hearing/Speech			

18	A	Enter an "X" in the appropriate box: Is the patient's vision, hearing, and speech normal?	☐ YES - Go to Section 9 ☐ NO - Go to Item 18B
	B	If there is a **vision impairment**, provide information about any deficiency in central visual acuity (before and after correction), peripheral visual fields, or other function. **Attach a copy of the visual field charts.**	
	C	If there is a **hearing impairment**, describe the limitations in the patient's hearing. **Attach a copy of any audiometric charts.**	
	D	If there is a **speech impairment**, describe any abnormalities in the patient's speech.	
SECTION 9 - Mental Functions			
19	A	Enter an "X" in the appropriate box: Does the patient have a severe mental impairment?	☐ YES - Go to Item 19B ☐ NO - Go to Section 10
	B	Describe the impairment, including emotional reactions, conduct disturbances, orientation, insight, judgment, hallucinations, delusions, memory for recent and remote events, and evidence of mental deterioration. Note any changes in the patient's normal activities of daily living. List medication(s) and response.	
SECTION 10 - Other Systems and Impairments			
20	A	Enter an "X" in the appropriate box:	☐ YES - Go to Item 20B

		Are there any impairments in other systems?	☐ NO - Go to Section 11
	B	Describe the impairment and provide any relevant findings.	

SECTION 11 - Exertional Restrictions

21	A	Enter an "X" in the appropriate box: Are there any exertional restrictions?	☐ YES - Go to Item 21B ☐ NO - Go to Section 12
	B	Describe, in detail, any type of exertional restriction (e.g., limitations on lifting, standing, walking, sitting, stooping, crouching, climbing, etc.)	

SECTION 12 - Environmental Restrictions

22	A	Enter an "X" in the appropriate box: Are there any environmental restrictions?	☐ YES - Go to Item 22B ☐ NO - Go to Section 13
	B	Describe any environmental restrictions (e.g., can the patient work around heights, around machinery, walk on uneven terrain, be exposed to dust, fumes, noise, vibration, temperature extremes etc.?).	

SECTION 13 - Certification

With the understanding that section 13 of the Railroad Retirement Act (45 U.S.C. 231l) provides that anyone who makes false or fraudulent statements or claims for the purpose of causing an award or payment under

the Railroad Retirement Act is subject to a fine of up to $10,000, or imprisonment of up to one year, or both, I certify that the information I have furnished is correct to the best of my knowledge.

Signature (*This report must be signed. A stamped signature is not acceptable)*	Date
Printed Name and Title	National Provider Identifier
Address and Daytime Telephone Number	Area Code / Telephone Number

Please return this form along with copies of your office records to:

RAILROAD RETIREMENT BOARD
OFFICE NAME
ADDRESS
CITY,STATE, ZIP

IMPORTANT NOTICES

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

The information requested on this form is authorized by Section 7(b)(6) of the Railroad Retirement Act. While you are not required to respond, your cooperation is needed to provide information necessary to complete processing for the claimant named and to determine the claimant's entitlement to disability benefits under the Railroad Retirement Act.

We estimate this form takes an average of 30 minutes per response to complete, including time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to ~~Chief of Information Resources Management~~ Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 N. Rush Street, Chicago, IL 60611-1275.

COMPUTER MATCHING AND PRIVACY PROTECTION ACT NOTICES

The Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) requires the Railroad Retirement Board to advise you that information you have provided may be used, without your consent, in automated matching programs. These matching programs are a computer comparison of RRB records with records kept by other Federal, state, or local governmental agencies. Information from the programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.