		*** * * * * * * * * * * * * * * * * * *					WID 110. 3220-0036		
		MED	ICAL ASSES	SMENT	Propos	sed			
SEC	CTIO	N 1 - Instructions							
ansv the i mov instr Ente	ver to nstru e thro uction r "NA	ms on this form will not apply to you a question, you may be told to ske ctions that tell you to "Go to" anothe bugh this Medical Assessment quiens are given, answer the next item and the Important Notices on page	tip to another item ner item. These an ckly, filling in only in order. Do not anown, as appropr	number, or e designed necessary ir skip any iter	even anot to save you oformation	ther section ou time and . If no "Go	n. Follow d help you o to"		
SEC	CTIO	N 2 - Patient Identification							
Rail	oad	Retirement Claim Number							
Soci	al Se	ecurity Number							
Nan	ne								
Add	ress		,						
Tele	phon	e Number	() -						
SEC	CTIO	N 3 - General Information							
1	Ent	er the date you began treating the	patient.		Year				
2	Ent	er the date of the last examination			Day	Year			
3	Ent	er the patient's weight and height.		Weight Height					
SEC	TIO	N 4 - Musculoskeletal System)						
4 A Enter an "X" in the appropriate box: Sthe musculoskeletal system normal? YES - Go to Section 5									
	В	Describe the impairment. Attach		y reports, M	RI reports,	CT scan re	eports, etc.		
5	Α	Enter an "X" in the appropriate b Is there a limitation of motion any joints?		a	nd enter e the ra an "N' motio	either: nge of mot ' for norma	I range of		

5	В		Norm Degre		Actual Degrees			Nor Dea	mal rees	Actual Degrees	
		CERVICAL SPINE			Dogrood	DORSOLUMBAR SPINE				Dogrood	
		Flexion	45			Flexion		90			
		Extension	45			Extension		30			
		Right Lateral Flexion	45			Right Lateral Fle	xion	30			
		Left Lateral Flexion	45			Left Lateral Flexion		30			
		Right Rotation	60								
		Left Rotation	60								
		SHOULDER		Righ	t Left	HIP		Ri		nt Left	
		Abduction	150			Abduction		10			
		Forward Elevation	150			Adduction	2	20			
		Internal Rotation	80			Flexion	10	00			
		External Rotation	80			Extension	3	30			
		ELBOW				Internal Rotation	2	10			
		Flexion	150			External Rotation	5	50			
		Extension	0			KNEE					
		Supination	80			Flexion	15	50			
		Pronation	80			Extension		0			
		WRIST				ANKLE					
		Dorsi-Flexion	60			Dorsi-Flexion	2	20			
		Palmar-Flexion	70			Plantar-Flexion		40			
6	Ent	ter an "X" in the appropriate	box:			│ │					
		Are there paraspinal muscle examination?				NO					
7	Des	scribe 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	ioint or mus	cle gro	un and grade)					_	
	L	oppor Extremity (Name left of Fight	joint of mus	Sele gro		•					
8	Des	scribe any seasory or reflex	abnor <u>m</u>	alities	-						
			re	flexes o	on a graded	scale (0 to 4+) and describ	e any s	sensor	y abnoi	malities.	
	L	ower Extremity (Name left or right jo	oint or musc	le grou	p and grade):						
	Upper Extremity (Name left or right joint or muscle group and grade):										
9	Α	Describe, in detail, the par	ient's ga	it and	station.						

9	В	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
	С	How far can the patient walk without using an assistive device?
10	Α	Enter an "X" in the appropriate box:
		Are there any abnormalities in the patient's hands or fingers?
	В	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.
SEC	CIT	N 5 - Cardiovascular System
11	Α	Enter an "X" in the appropriate box:
		Is the cardiovascular system normal?
11	В	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	Des	scribe any signs of congestive heart failure.

13 Describe any rhythm disturbances.	
Describe any evidence of arterial or venous insufficiency (e.g., intermittent claudication, pulse deficit	· S
brawny edema, etc.).	Ο,
SECTION 6 - Respiratory System	
15 A Enter an "X" in the appropriate box:	
Is the respiratory system normal?	
B Provide detailed objective findings. Attach a copy of any pulmonary function test (including	n
tracings), x-ray reports, or sputum culture results.	9
SECTION 7 - Neurological System	
16 A Enter an "Y" in the appropriate boy:	
Is there a neurological impairment?	
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.	
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Seizure disorder.	
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of any audiometric charts. D	18	Α	Enter an "X" in the appropriate box:
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? B Describe the impairment, including emotional reactions, conduct disturbances, orientation, insigh judgment, hallucinations, delusions, memory for recent and remote events, and evidence of mend deterioration. Note any changes in the patient's normal activities of daily living. List medication(s and response.			is the patient's vision, hearing, and speech
(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? B Describe the impairment, including emotional reactions, conduct disturbances, orientation, insigh judgment, hallucinations, delusions, memory for recent and remote events, and evidence of ment deterioration. Note any changes in the patient's normal activities of daily living. List medication(s and response.			normal?
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∠∪ A ⊑nter an A in the appropriate box: YFS - Go to Item 20B	20	A	Enter an "X" in the appropriate box:

		Are there any impairments in other systems? NO - Go to Section 11
	В	Describe the impairment and provide any relevant findings.
21		N 11 - Exertional Restrictions
21	Α	Enter an "X" in the appropriate box:
		Are there any exertional restrictions? NO - Go to Section 12
	В	Describe, in detail, any type of exertional restriction (e.g., limitations on lifting, standing, walking,
		sitting, stooping, crouching, climbing, etc.)
SEC	CTIO	N 12 - Environmental Restrictions
22	Α	Enter an "X" in the appropriate box:
		Are there any environmental restrictions? NO - Go to Section 13
	В	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.?).
		CARCINGS Cto.: j.
000	TIA	N 42 Contification
2F(, HO	N 13 - Certification

With the understanding that section 13 of the Railroad Retirement Act (45 U.S.C. 231I) 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.																	
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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, Railroad Retirement Board, 844 N. Rush Street, Chicago, IL 60611.1.1275.

Associate Chief Information Officer for Policy and Compliance

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.