****BARCODE****

AGENCY
LETTERHEAD

Date: _____
Claim ID: _____

Addressee Name
Address Line 1
Address Line 2
City, State, ZIP Code

Claimant: [Fill-in]
DOB: xx/xx/xxxx

We are the office that makes the disability determinations for the Social Security Administration. **[First Name] [Last name]** is applying for or is receiving disability benefits due to the following conditions: ***[List Conditions]***

Please provide medical reports including the following information: medical history, clinical findings, laboratory findings, treatment prescribed and the response, diagnosis, and prognosis.

Please send the information requested below, covering the period of **[*Fill-in date*] to [*Fill-in date*]**, to help us evaluate this claim.

- **[*Fill-in*]** (e.g. history, diagnosis/prognosis, most recent mental status exam, etc.)
- **[*Fill-in*]**

We are enclosing a signed, HIPAA compliant authorization (SSA-827) for release of medical records and information.

[*Optional canned text for claims involving mental impairments*]
Please provide a statement based on your findings. Your statement should express your opinion about your patient's ability to do work-related mental activities *despite the limitations imposed by his/her mental condition(s).* These activities include: understanding, carrying out and remembering instructions, and responding appropriately to supervision, coworkers, and work pressures.

[*Optional canned text for claims involving physical impairments*]
Please provide a statement based on your findings. Your statement should express your opinion about your patient's ability to do work-related physical activities *despite the limitations imposed by his/her medical condition(s).* These activities include sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling.

[*Optional canned text for a claim for a child*]
Please provide a statement based on your findings. Your statement should express your opinion about your patient's abilities and limitations compared with children of the same age without medical conditions. Consider areas such as, but not limited to, age-appropriate learning, attention, interaction with other people, motor functioning, and behavior and self-care. Please also comment on how this child's medical condition(s) and associated treatments, including the frequency of treatment, affect his or her overall functioning.

Submitting Records: Refer to the instructions on the bar-coded cover page.

Payment Information: We will pay you for your report and records. See the attached invoice for instructions. To receive payment, you must complete the attached invoice and submit it with the requested records and statements within **[Fill-in#]** days of the date of this letter.

[*Optional canned text*]
We do not pay any State or Federal facility. If you are in such a facility, you will not find a voucher in this request.

For billing questions or inquiries please call x-xxx-xxx-xxxx.

Other Information: Please indicate if you would be willing to conduct an examination, test, or both at our expense if we later determine that we need more medical information. If you do not respond, we will assume that you do not wish to conduct such an examination of this patient.

_____ Yes, I am interested. _____ No, I am not interested.

If you have any other questions please contact **[*Mr./Ms.*]** **[*Disability Examiner's name*]** at xxx-xxx-xxxx.

If you have no records for this patient please check here _____

CLAIMANT:
DDS CASE NUMBER:
DEA: ATE000

DIABETES QUESTIONNAIRE FOR TREATING SOURCE

1. Please include treatment notes, and lab tests from _____ to _____
2. Diagnosis _____

3. Date of onset of symptoms. _____
4. Height _____ Weight _____ Date _____

5. Date and results of the latest blood sugar evaluation and glycohemoglobin (HbA1C).
   _____

6. If acidosis has occurred on the average of at least once every two months, please indicate blood chemical test (PH or PCO2 or bicarbonate levels) and the dates performed. _____
   _____

7. If the patient has sustained an amputation due to diabetic necrosis or peripheral vascular disease, please describe and indicate the date of the amputation.
   _____
   _____

8. If present, please describe any visual abnormalities due to diabetes. _____
   _____

9. Is there any evidence of neuropathy? If so, please describe. Is an assistive device medically required for ambulation? When was it prescribed? _____
   _____

10. Is the Diabetes under satisfactory control? ☐ Yes ☐ No

11. Please describe compliance and response to treatment. _____
    _____
    _____

12. Please indicate any other observable conditions or pertinent clinical findings that might affect the patient's functional abilities. _____

13. Date first seen:_____ Date last seen:_____ Frequency of visits:_____

Thank you for your cooperation.

Physicians Signature _____ Print or type name _____
Date _____
Phone Number_____ Best time to call _____

CLAIMANT:
DDS CASE NUMBER:
DEA: ATE000

Treating Physician
General Medical Evaluation

Directions: Please provide a current assessment using objective findings. This information is necessary to evaluate this patient's disability claim. ***Please indicate if normal. If abnormal, please list specific findings.*** (Please use reverse side if additional space is needed.)

Date of Exam:_____ **Frequency of Visits:**_____

General Appearance

1. Height:_____ Weight:_____ Blood Pressure:_____

Eyes

2. Best Corrected: OD _____ OS _____
3. If uncorrected give: OD _____ OS _____
4. Describe any severe disease/visual defect (including visual fields):_____

Ears

5. Can your patient hear normal conversation? Yes ☐ No ☐
   If no, please explain._____

Respiratory System

6. Lungs:_____
7. Details of dyspnea, if any:_____

Cardiovascular

8. Chest pain of cardiac origin? Yes ☐ No ☐
   If yes, please describe, including symptoms:_____
9. Peripheral vascular pulses:

Abdominal

10. Abdomen/pelvis findings:_____

11. Organomegaly? Yes ☐ No ☐
If yes, please describe._____

Musculoskeletal

12. Please provide range of motion (ROM) and describe affected joint(s) and/or spine.

Neurological System

13. Please describe the following:

a. Gait:_____
b. Reflexes:_____
c. Sensory:_____
d. Motor:_____
e. Atrophy? Yes ☐ No ☐
If yes, please describe._____

f. Does your patient have seizures? Yes ☐ No ☐
If yes, please describe (including frequency)._____

Comments:

14. Please provide comments below on other conditions your patient has which are not already described above.

Name of Physician (printed) **Physician Signature**

Date _____ **Telephone # and extension: (_____)**_____

CLAIMANT:
DDS CASE NUMBER:

DEA: ATE000

TREATING SOURCE SUMMARY OF VISION FINDINGS

1. DIAGNOSIS: OD_____

   OS_____

2. DISTANCE VISUAL ACUITY:

   Without correction (leave blank if not checked): OD_____ OS_____ Date_____

   With correction (leave blank if not tested) OD_____ OS_____ Date_____

   Most recent **manifest refraction:** Date _____ Check here if unknown ☐

   OD _____ = 20/_____

   OS _____ = 20/_____

3. Describe any pathological findings:_____

4. What surgery has been performed? None ☐

   OD _____ Date_____

   OS _____ Date_____

5. Has formal **Visual Field** testing been done? Check all that apply.

   ☐ No. ☐ No significant visual field deficit expected.

   ☐ Yes. Was this a reliable field consistent with ocular pathology? ☐ Yes ☐ No

   Date of test _____

   Please include the visual field printouts with this report.

6. Indicate earliest date:
   Best corrected VA in the better eye was limited to 20/200 or worse:
   N/A ____ Date: _____
   Residual visual field in the better eye was 20 degrees or less in widest diameter:
   N/A ____ Date: _____
   Please include supporting clinic notes or VF test results for that date.

7. Please comment on **treatment plan** and **prognosis** over the next 12 months:

_____

_____

_____

Signature of: Physician ☐☐ Optometrist ☐ Date

( )

_____

MD/OD Name (please print) Phone No. Best time to contact you

Cardiac Questionnaire Doctor-Adult

Form Approved
OMB No. 0960-0555

[Standard Header]
Patient Name: {clmt_full_name}

{barcode}

PLEASE COMPLETE AND RETURN BY {mer_return_date}

CARDIAC QUESTIONNAIRE

1) Diagnosis: _____ Date of diagnosis: _____

2) Date and findings of most recent exam: _____

_____

3) Would undergoing exercise testing pose significant risk for your patient? ☐ Yes ☐ No

4) If the patient has chest pain, is it related to a cardiac condition? ☐ Yes ☐ No

If no, what non-cardiac condition is causing chest pain? _____

5) Has the patient experienced cyanosis at rest? ☐ Yes ☐ No On exertion? ☐ Yes ☐ No

6) Describe the patient's cardiac signs and symptoms (for example, dyspnea, fatigue, palpitations, chest discomfort, edema, varicosities, stasis dermatitis, ulcerations, claudication).

_____

_____

7) Describe the location, duration, and frequency of the patient's symptoms. _____

_____

8) Describe any precipitating factors (for example, physical activity, eating, cold air). _____

_____

9) What relieves the patient's symptoms (for example, rest, position, medication)? _____

_____

10) Are the symptoms acute or chronic? _____

11) Current New York Heart Association class rating: _____. Based on this rating describe the patient's physical limitations (for example, difficulty with household tasks, walking, stairs, lifting).

_____

_____

_____

_____

12) Describe any evidence of neurological complications (for example, ataxia, paralysis, aphasia).

_____

_____

13) Is there evidence of end-organ damage as a result of hypertension (for example, kidney failure, retinopathy)? ☐ Yes ☐ No

If yes, describe. _____

_____

Treatment:

MEDICATION	DOSAGE AND FREQUENCY

PAST TREATMENT OR RECOMMENDATION(S) (for example, angioplasty, CABG, pacemaker)	DATE PERFORMED OR SCHEDULED

14) Have the symptoms persisted despite treatment? _____

_____

15) Describe any restrictions to work-related activities, if not previously provided (for example, walking, lifting, carrying).

_____

_____

_____

_____

_____

NOTE: Please submit copies of tracings, testing, and laboratory results, if you have not provided them previously.

_____	_____	_____
Physician's Signature	Date	Phone Number
_____		_____
Printed Name		Title

[Paperwork Reduction Act]

Form Approved
OMB No. 0960-0555

[Standard Header]
Patient Name: {clmt_full_name}

{barcode}

PLEASE COMPLETE AND RETURN BY {mer_return_date}

EPILEPSY QUESTIONNAIRE

1) Date of most recent examination: _____

2) Diagnoses: _____

3) Indicate the type of seizures: ☐ Convulsive ☐ Non-Convulsive

4) Dates of last two seizures: _____ ____ _____

5) Describe typical seizures (include all associated phenomena, such as aura, loss of consciousness, tonic or clonic movement, incontinence, alteration of awareness, unconventional behavior, duration, etc.).

_____

_____

_____

6) Describe postictal manifestations and duration. _____

_____

_____

7) If convulsive, when do episodes occur?

☐ Day (with loss of consciousness and convulsive seizures) ☐ Night

8) Seizures witnessed by physician or staff member? ☐ Yes ☐ No

If yes, describe. _____

_____

_____

9) Treatment:

MEDICATION	DOSAGE AND FREQUENCY	SIDE EFFECT(S)

10) Other treatment: _____

_____

_____

11) Are seizures controlled with medication? ☐ Yes ☐ No

If no, explain. _____

_____

_____

12) Frequency of seizures after prescribed treatment: _____

_____

_____

13) Serum levels:

DRUG	DATE	RESULT

14) If serum drug levels are therapeutically inadequate, explain further. _____

_____

_____

15) Describe any functional limitations resulting from the patient's condition (for example, driving, physical activity, hazardous conditions). _____

_____

_____

16) Describe any restrictions to work-related activities, if not previously provided (for example, walking, lifting, carrying). _____

_____

_____

_____

_____

NOTE: Please submit copies of any testing and laboratory results, if you have not provided them previously.

_____	_____	_____
Physician's Signature	Date	Phone Number

_____	_____
Printed Name	Title

[Privacy Act Statement]
[Paperwork Reduction Act]

Cardiac Questionnaire Doctor-Child

[Standard Header]
Child Name: [ClmFtNm] [ClmLtNm]

[Barcode]

PLEASE COMPLETE AND RETURN BY [CalcReturnDate]

CHILD CARDIAC QUESTIONNAIRE

1. Diagnosis: _____ Date of diagnosis: _____

2. Date and findings of most recent exam: _____
   _____

3. Current height and percentile: _____ Current weight and percentile: _____

4. For children under two: Birth Length: _____ Birth Weight: _____

5. Has the child had involuntary weight loss or failure to gain weight that has persisted for two months or longer? ☐ Yes ☐ No If yes, provide copies of records to include longitudinal history of height, weight, and growth percentiles. _____
   _____
   _____

6. For children age six or older, would undergoing exercise testing pose significant risk for the child? ☐ Yes ☐ No

7. If the child has chest pain, is it related to a cardiac condition? ☐ Yes ☐ No If no, what non-cardiac condition is causing chest pain? _____

8. Describe the child's cardiac signs and symptoms (for example, syncope, cyanosis, edema, dyspnea, weakness, palpitations, weight loss or gain). _____
   _____
   _____

9. Describe the location, duration, and frequency of the child's symptoms. _____
   _____

10. Describe any precipitating factors (for example, physical activity, eating, cold air). _____
    _____

11. What relieves the child's symptoms (for example, rest, position, medication)? _____
    _____

[Standard footer]

12. Are the symptoms acute or chronic? _____

13. Describe any evidence of neurological complications (for example, weakness, spasticity, incoordination, ataxia, tremor) resulting from the child's cardiac condition(s).
_____
_____

14. Is there evidence of end-organ damage as a result of hypertension (for example, kidney failure, retinopathy)? ☐ Yes ☐ No If yes, describe._____
_____

15. Describe any cognitive deficits resulting from the child's cardiovascular disease or treatments for the cardiac condition(s). _____
_____
_____

16. Treatment:

MEDICATION	DOSAGE AND FREQUENCY

PAST TREATMENT OR RECOMMENDATION(S) (for example, pacemaker, defibrillator, corrective surgery)	DATE PERFORMED OR SCHEDULED

17. Have the symptoms persisted despite treatment? _____
_____

18. Describe any restrictions to age appropriate activities, if not previously provided (for example, acquiring and using information, attending and completing tasks, interacting and relating with others, moving about and manipulating objects, self-care).
_____
_____
_____
_____

NOTE: Please submit copies of tracings, testing, and laboratory results, if you have not provided them previously.

.

Physician's Signature	Date	Phone Number

Printed Name	Title

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a) and 1631(d) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on the claimant's eligibility for benefits.

We will use the information to make a determination of eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To Federal, State, or local agencies for administering cash or non-cash income maintenance or health maintenance programs; and

2. To contractors, and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We contemplate disclosing information under this routine use only in situations in which SSA may enter a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0044, entitled National Disability Determination Services File System and 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - 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 (OMB) control number. We estimate that it will take about 12 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*