

SSA-454 EDCS Child Screenshot

SSA - 454 Section 1 – Information About You:

454 About You

Identification

Name: [REDACTED]

Primary telephone number: [REDACTED]

Secondary telephone number is: ☐ U.S. ☐ Foreign ☒ None

Secondary telephone number: Ext:

E-mail address:

The Child's Language Information

Can the child speak and understand English?

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

☒ Yes ☐ No ☐ Not yet answered

If NO, what language does the child prefer?

Other Names Used

In the last 12 months, has the child used any other names on his or her medical or educational records?

Examples are maiden name, other married name, or nickname

☐ Yes ☒ No ☐ Not yet answered

SSA - 454 Section 2 – Contacts/Person Completing Form

454 Someone we can contact

Alternate Contact Information

Is there someone (other than the child's doctors) we can contact who knows about the child's medical condition(s), and can help with the case? Examples include a family member, friend, or neighbor.

☒ Yes ☐ No ☐ Not yet answered

Name of Alternate Contact

First name: Middle name: Last name: Suffix:
Relationship to Child:

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 phone number: (999-999-9999) Ext:

Preferred Language of Alternate Contact

Can this person speak and understand English?

☐ Yes ☐ No ☒ Not yet answered

Person Completing the Report

Who is providing information?

☐
☐ Alternate Contact listed above
☒ Someone else

Name of Person Completing This Report

First name: Middle name: Last name: Suffix:
Agency name:
Relationship to Child:

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 phone number: (999-999-9999) Ext:

SSA - 454 Section 3 – Medical Info – Conditions

454 Medical Information - Medical Conditions

Physical and Mental Conditions

*Separately list each physical and/or mental health condition that limits the child's ability to do the same things as other children of the same age.

Include:

- All physical, mental, or emotional conditions
- Any major complications resulting from your condition
- All conditions, whether or not you have been receiving treatment
- If cancer, include stage and type

Examples of conditions:

1. Back injury, 2. Arthritis, 3. Diabetes, 4. Glaucoma, 5. Depression, 6. Blindness

Enter one condition on each line. You will be given additional lines as needed.

*1.

Height and Weight

What is the child's height? feet: inches:

What is the child's weight? pounds:

SSA - 454 Section 3 – Medical Info – Sources

Medical Sources Summary

454 Medical Information - Medical Sources

Comparison Point Decision Date: 03/20/2023

Doctors, Therapists, Hospital, Clinics

*Within the last 12 months, has the child seen or received treatment from a health care provider (doctor, hospital, clinic, psychiatrists, nurse practitioners, therapists, physical therapists, or other medical professionals)?

☒ Yes ☐ No ☐ Not yet answered

Tell us who may have medical records covering the last 12 months about any of the child's **physical or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities.

Tell us about the child's next appointment, if one is scheduled.

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

Name	Address

Medical Sources – Doctor/Therapist Information DETAIL (no edits)

Doctor/Therapist Information - AN: 713-49-1509 CDR CEF: Y CPD CEF: NYA

Open in eView Hide Instructions

Doctor/Therapist Information

Comparison Point Decision Date: 03/20/2023

Name: MARYLAND CTR FOR EYE CARE

Replace Source

Attention:

Address: 419 W REDWOOD ST #477

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:

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

Add Test

Medicines

List all medicines the child is now taking, or has taken in the last 12 months, 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
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Add Medicine

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.

To add or edit a condition, choose Add or Edit Conditions.

Name

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

Help

Medical sources – Hospital/Clinic Information

Hospital/Clinic Information

Comparison Point Decision Date: 03/20/2023

Name of facility or office: [MARYLAND FAMILY CARE](#)

[Replace Source](#)

Attention:

Address: 2801 FOSTER AVE

Health care professional who treated the child at MARYLAND FAMILY CARE:

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 the child 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 the child have any outpatient visits? ☐ Yes ☐ No ☒ Not yet answered

Did the child have any emergency room visits?

If more than three, give the most recent ones.

☐ Yes ☐ No ☒ Not yet answered

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 the child 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 or sent the child to within the last 12 months, or scheduled the child 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
Blood test (Not HIV)	Nov 2021	MARY LAND FAMILY CARE

[Add Test](#)

Medicines

List any prescription or non-prescription medicines the child is now taking, or has taken in the last 12 months, 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
Concerta	MARY LAND FAMILY CARE	ADHD meds may treat symptoms, so trying this.

[Add Medicine](#)

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.

To add or edit a condition, choose Add or Edit Conditions.

Name
Late effects of injuries to the nervous system

[Add or Edit Conditions](#)

SSA- - 454 Section 3 – Medical Info – Tests

Test Summary

454 Tests Summary

Within the last 12 months, did any of the providers you listed order any test for the child? (Include test already performed and those scheduled in the future)

☒ Yes ☐ No ☐ Not yet answered

List all tests that the child had or will have for his or her condition.

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

Test	Date	Ordered By
IQ testing	Nov 2021	Other medical professional
Speech/Language	Oct 2021	Provider LN, Provider FN TITLE, Dr. Ped

[Add Test](#)

Test Detail

Test Information

Name of Test:
[See condition of tests](#)
EEG (Brain wave test) ...

Date of Test:
If you can't remember the exact dates, be as specific as possible. Examples:
• 10/13/2002
• June 2001

summer 2019

Provider who performed, sent, or scheduled the child to take this test.
If you need to add a medical source, you must return to MED SOURCES.
McDonalds, Tina

☒ I have had this test more than once.

Physical and Mental Conditions
List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.
To add or edit a condition, choose Add or Edit Conditions.

Name
Down Syndrome
Low vision

Add or Edit Conditions

OK

Delete

Add Another

Cancel

Help

SSA - 454 Section 3 – Medical Info – Medicines

Medicines Summary

454 Medical Information - Medicines Summary

Within the last 12 months, has the child taken or is the child now taking any prescription or non-prescription medicines?

☒ Yes ☐ No ☐ Not yet answered

List all prescription and non-prescription medicines that the child takes for his or her condition.

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

Medicine	Prescribed By	Reason
Concerta	MARYLAND FAMILY CARE	ADHD meds may treat symptoms, so trying this.

Add Medicine

Medicines Detail (no edits)

Medicine Information - AN: 713-49-1509 CDR CEF: Y CPD CEF: NYA

Medicine Information

Name of medicine:

Who prescribed this medicine (if prescription)?

If you need to add a medical source, you must return to MED SOURCES.

Reason for medicine:

Examples:

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

ADHD meds may treat symptoms, so trying this.

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit the child's ability to do the same things as other children of the same age.

To add or edit a condition, choose Add or Edit Conditions.

Name
Late effects of injuries to the nervous system

Add or Edit Conditions

SSA - 454 Section 3 – Medical Info – Assistive Devices

Assistive Devices Summary (new)

454 Medical Information - Assistive Devices

Does the child use an assistive device?
☒ Yes ☐ No ☐ Not yet answered

List the assistive device(s) you use.

To add a device, choose **Add Device**. To edit, select the device listed below.

Medicine	Prescribed By
Eyeglasses	*No Source
Canes	Orthopedic Associates
Walker	Orthopedic Associates

Add Device

Assistive Devices Detail (new)

454 Assistive Devices

Name of Device
Other

If "other", please describe what kind of device, when and how you use it.
Scooter - I use this in the house

How frequently do you use this device?
Note: if you always use an assistive device when outside of your home, but do not always use it inside of your home, select "always."
☒ Always ☐ Sometimes ☐ Not Yet Answered

Provider who prescribed or advised you to use the device
If you need to add a medical source, you must return to MED SOURCES.
I don't know

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.
To add or edit a condition, choose Add or Edit Conditions.

Name

SSA - 454 Section 9 – Remarks

454 Remarks

Please provide any additional information you did not give in earlier parts of this report.

DRAFT