Santa Cruz County
Human Services Department
P.O. Box 1320
Santa Cruz, CA 95060
888-421-8080

MEDICAL STATEMENT
DOCTOR'S CONFIDENTIAL REPORT

Case Name:
Case Number:
Last Four (4) Digits of Social Security Number:

I authorize release of requested information from my record for the use of the Santa Cruz County Human Services Department. I know this authorization may be used by the Santa Cruz County Human Services Department for up to one year from this date to obtain medical information. I may revoke this authorization at any time, except for information that has already been given to the agency. This information is needed to determine eligibility for cash aid or food assistance. It is also needed to decide the type of work or training activities that I can participate in. I have read this form (or had this form read to me) before I signed my name. I know I can get a copy of this form if I ask for it.

Patient's Signature_____ Date_____

Medical Provider:

Please completethis report evaluating the individual listed below for health conditions that may prevent them from being able to work.

Patient's Name:	Date of Birth:
Address:	

Medical Evaluation:

Date of Examination:	Diagnosis Code:
Diagnosis:	
Onset of Condition:	

Descriptive statement of medical condition(s) and remarks:

Medical Statement:

A. Does this individual's medical condition prevent them from working?

☐ **NO** ☐ **YES** If yes, is this situation:

[ ] Temporary (If temporary,condition will improve in): _____ (months)
[ ] Persistent (not able to workfor 12 mos. or more)

Ifcondition is persistent has it existed for 12 months or more?

[ ]Yes [ ]No [ ]Insufficient information to make determination [ ] Other: (*Explain*)

B. Inrelation to the medical condition(s), the patient retains the capacity to:

1. **Occasionally** lift and/or carry (including upward pulling) for up to 1/3 of an 8-hour workday a maximum of:

☐ less than 10 pounds ☐ 10 pounds ☐ 20 pounds ☐ 50 pounds ☐ 100 pounds ☐ cannot assess

2. **Frequently** lift and/or carry from ⅓ to ⅔ of an 8-hour workday a maximum of:

☐ 10 pounds ☐ 25 pounds ☐ 50 pounds ☐ cannot assess

3. **Stand and/or walk** (with normal breaks) for a total of:

☐ less than 2 hours in an 8 -hour workday ☐ at least 2 hours in an 8-hour workday
☐ about 6 hours in an 8-hour workday ☐ cannot assess

4. **Sit** (with normal breaks) for a total of:

☐ less than about 6 hours in an 8-hour workday ☐ about 6 hours in an 8-hour workday ☐ cannot assess

C. Does the patient have other physical limitations related to the medical condition(s)?

☐ **NO** ☐ **YES** If yes, please describe any other significant physical limitations such as postural, manipulative, environmental, visual, aural, speech, drug or alcohol abuse/dependency.

D. I recommend that patient be referred for an evaluation of behavioral health conditions that may prevent them from being able to work.

☐ **NO** ☐ **YES** If yes, please state reason.

Alcohol and Other Drugs

Alcoholism: ☐ Yes ☐ No ☐ Probable *(Explain)*

Drug Abuse: ☐ Yes ☐ No ☐ Probable (Explain)

Doctor's Name (Please Print)

Specialty

Doctor's Signature Date

Address

Physician's License # (required)

Telephone Number

Fax Number

If the person completing this form is not a medical doctor, please sign below:

Name (Please Print)

Title (Please Print)

Signature Date