CONDADO DE SANTA CRUZ
DEPARTAMENTO DE SERVICIOS HUMANOS
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:

A utorizó el uso de la información solicitada de mis registros por el Departamento de Servicios Humanos del Condado de Santa Cruz. Sé que esta autorización puede ser utilizada por el Departamento de Servicios Humanos del Condado de Santa Cruz por un máximo de un (1) año a partir de esta fecha para obtener información médica. Puedo revocar esta autorización en cualquier momento, a excepción de la información que ya ha sido entregada a la agencia. Esta información es necesaria para determinar elegibilidad para ayuda monetaria o asistencia alimentaria. También es necesaria para decidir el tipo de trabajo o actividades de entrenamiento en las cuales puedo participar. He leído esta autorización (o alguien me la ha leído) antes de firmar mi nombre. Sé que puedo obtener una copia de esta autorización si la pido.

Firma del Paciente_____ Fecha _____

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

Physician's License # (required)

Address

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