NEW YORK STATE DEPARTMENT OF HEALTH Disability Review Unit

Medical Report for Determination of Disability

Section I – Identific	ation								
Agency State Disability Review Unit OCP-826 State of New York Department of Health Albany, NY 12237 Telephone Number: 1(866) 330-0591		Patient Name (Last, First, Middle)			Date of Birth		Client II	Client ID Number	
		Address (Street, City, State	& Zip Code):		Sex Male Female Case Number		Disability ID Number		
							SSN (las	SSN (last four digits)	
Section I – Medical	Report – Note to Provid	er							
capabilities and limitat	tions, is requested. Your pro	ation) for Disability Medicai omptness will ensure an ear n Section I above, along wi t	ly decision on the ind	dividual's application.		lividual's curren	t condition, focus	sing on both remaining	g
Diagnosis(es)							Date of last exam		
								ft	
							Weight	lbs.	
Exertional Function	ns. Please indicate what	the individual is CAPAB	LE of doing:						
Lifting < 10 lbs. Max. 10 lbs. Max. 20 lbs./freq. 10 Max. 50 lbs./freq. 21 > 50 lbs. 		bs. 10 lbs. 20 lbs./freq. 10 lbs. 50 lbs./freq. 25 lbs.	Standing C < 2 hrs./day 2 hrs./day 6 hrs./day	Walking < 2 hrs./day 2 hrs./day 6 hrs./day	Sitting □ < 6 h □ 6 hrs		Pushing Using R arm Using L arm Using R leg Using L leg		
Non-Exertional Fun	nctions. Please check if I	LIMITATIONS exist in any	of the areas belov	v:					
Sensory No Limitations Seeing Hearing Speaking	Postural Manipulative s No Limitations No Limitations Stooping/Bending R Upper Extremity Crouching/Squatting L Upper Extremity Climbing Climbing				•			uctions	
Provider Signature			Print Name			Date Signed			
Specialty			Office Address			Office Phone Number			
DOH-5143 (8/18)	PLEA	SE RETURN THIS FORM AL	ONG WITH A COPY O	F ALL MEDICAL RECO	RDS FOR THE PA	ST 12 MONTHS.			