



COUNTY OF ORANGE
SOCIAL SERVICES AGENCY

REQUEST FOR MEDICAL/MENTAL HEALTH REPORT OF EXAMINATION

The following information is required to help us determine eligibility for assistance to the individual named below based upon his or her ability to work. The information you provide will not be shared with any other government or private agency.

Worker Name:	Phone #:	Fax #:
Region Address:		

Patient's Name:	Patient's DOB:
County Case Number:	

THE FOLLOWING SECTION TO BE COMPLETED BY MEDICAL/MENTAL HEALTH CARE PROVIDER AND EITHER FAX OR MAIL TO SOCIAL SERVICES AGENCY REGIONAL OFFICE BY: _____

1. Provider's Name:	
2. Provider's Address:	
3. Provider's Phone #:	4. Medical/Professional License #:
5. Does the patient have medical and/or mental health condition(s) that result(s) in anatomical, physiological, or psychological abnormalities established by objective medical evidence (such as signs or laboratory findings) excluding an individual's statement of symptoms, that prevents them from participating in <u>any</u> type of employment (including part-time employment): <input type="checkbox"/> <u>Yes</u> , skip to item # 7 <u>OR</u> <input type="checkbox"/> <u>No</u> , complete item # 6	
6. Please describe any specific limitations that may affect the patient's ability to work: Maximum number of hours per day patient is able to work = _____ Maximum number of days per week that patient is able to work = _____	
7. Please list the patient's medical and/or mental health condition(s) that prevents employment: Date of onset:	
8. Do these medical and/or mental health condition(s) cause <u>more than moderate</u> limitations in their activities of daily living? (such as limitations related to showering, dressing, cooking, meal prep, household chores, shopping and paying bills) <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Duration of condition that prevents employment and type of Disability Status: (check one) <input type="checkbox"/> <u>Temporary Disability</u> = The patient will be able to return to full or part time work within the next 12 months on _____ (provide date) <input type="checkbox"/> <u>Permanent Disability</u> as defined by the Social Security Administration = patient is <u>not expected</u> to return to full or part time work.	
10. Provider Certification: Signature: _____ Date: _____	