RA-21 (Rev. 10.2012)

MICHIGAN DEPARTMENT OF HUMAN SERVICES
MICHIGAN REHABILITATION SERVICES

GENERAL MEDICAL EXAMINATION REPORT

Office Name and Address

STATEMENT TO PHYSICIAN *(IMPORTANT – Please read carefully)*

Michigan Rehabilitation Services helps people with physical and mental limitations prepare for, find, and maintain jobs. Your report of findings and limitations will be used to help select a compatible job.

You are authorized to examine the person identified below. If, during the examination, you determine that x-rays and/or laboratory studies are needed to complete the heath appraisal, you must call the counselor listed below and request approval.

INSTRUCTIONS -
- ***District office completes Parts I and II.***
- ***Physician completes Part III – VI and signs the certification.***

I. APPLICANT/PATIENT IDENTIFICATION

Last Name	First Name	Middle Name	Date of Birth
Address *(number and street)*	(*City)*	*(State)*	*(Zip Code)*
Applicant reports the following conditions and limitations:			
		Usual Occupation	

II. REFERRAL INFORMATION

Referring Counselor	Area Code & Phone Number	Date

III. EXAMINATION RESULTS

Applicant is: ☐ A regular patient of this physician ☐ Being examined by me for the first time

Height *(without shoes)*	Weight	Blood Pressure	Pulse

Near Vision *(Jaeger Test)* Right: Left:	Corrected Right: Left:
Far Vision *(Snellen Chart)* Right: Left:	Corrected Right: Left:
Ears Right: Left:	Hearing Right: Left:

Examination Areas		Normal (√)	Abnormal *(Describe)*
General & Psychiatric	*(Pes planus, pallor, icterus, eruptions, tumors, deformities, ulcers, tremors, mental status)*	☐	
Eyes	*(Strabismus, cataract, scars, glaucoma, ptosis, nystagmus, discharge, pterygium)*	☐	
Ears	*(Evidence of deafness, middle ear or mastoid disease, drums absent, perforated, dull, retracted, discharge)*	☐	
Nose & Throat	*(Obstruction, evidence of chronic sinus, polyps, infection, tonsils: enlarged, removed)*	☐	
Neck	*(Thyroid enlargement, nodules, masses)*	☐	
Mouth, Teeth &/or Dentures	*(Missing teeth, pyorrhea, caries, abnormal tongue or palate, effect on general health and disability)*	☐	
Heart	*(Enlargement, murmurs, rhythm, dyspnea, cyanosis, thrills, edema)*	☐	
Lungs	*(Conformation, respiratory movement, breath sounds, rales, dullness)*	☐	

Examination Areas		Normal (√)	Abnormal *(Describe)*
Breasts	*(Abnormal discharge, nodules, tenderness)*	☐	
Abdomen	*(Liver, kidney, spleen, masses, spasm, tenderness, scars)*	☐	
Genitalia-male	*(Discharge, varicocele, hydrocele, prostate, KUB tract)*	☐	
Gynecological	*(Pelvis, describe significant abnormal condition, severity and extent)*	☐	
Rectum	*(Severity and extent of hemorrhoids, prolapse, fissures, fistula, tumors, stenosis, etc.)*	☐	
Hernia	*(Site, type, severity)*	☐	
Veins & Arteries	*(Varicose veins: location, severity; peripheral pulsations)*	☐	
Musculo-skeletal/ Extremities	*(Congenital or acquired impairments, feet, back, amputations, etc.)*	☐	
Nervous System	*(Motor, sensory, speech, gait, reflexes, paralysis, coordination, sensation)*	☐	

IV. LABORATORY & X-RAY STUDIES *(if performed)*

Test	Findings	
TB Test *(Mandatory for MCTI students)*	Findings	Date

V. DIAGNOSIS

Conditions that result in limitations
Medical conditions that are under control and do not result in limitations

VI. CLINICAL IMPRESSIONS

Characteristics of the limiting condition(s) *(check appropriate terms)*

☐ Permanent ☐ Temporary ☐ Stable ☐ Slow Progression ☐ Rapid Progression ☐ Improving

Can the condition be removed by treatment?	Substantially reduced by treatment?	Are you providing treatment?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Physical Capacities *(check those with limitations)*

PHYSICAL ACTIVITIES

☐ Walking ☐ Standing ☐ Stooping
☐ Kneeling ☐ Lifting ☐ Climbing
☐ Reaching ☐ Pushing ☐ Pulling
☐ Other *(specify) :* _____

WORKING CONDITIONS

☐ Outside ☐ Inside ☐ Humid
☐ Dry ☐ Dusty
☐ Sudden temperature change
☐ Other *(specify) :* _____

Employability Status

☐ Is this patient now physically able to enter employment or training? ☐ Yes ☐ No

☐ Full-time *(6 or more hours)* ☐ Part-time Limitations: _____

Recommendations *(Identify significant medical conditions that must be further evaluated before this person can begin employment. Please use additional sheet for remarks and expansion of any of the above items.)*

CERTIFICATION I certify that all services were rendered without regard to race, color, national origin, religion, age, sex, marital status, or disability in accordance with the Civil Rights Provision of the State of Michigan, Title VI, of the Civil Rights Act of 1964, Title IX Educational Amendments of 1972, and Sections 503 and 504 of the Rehabilitation Act of 1973 as amended.

Physician's Signature	Physician's Name *(type or print only)*		Date
Address *(Number & street)*	*(City)*	*(State)*	*(Zip Code)*