OFS 90AD
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Louisiana Department of Children and Family Services

Medical Evaluation Addendum
Physician's Report

Consent to Disclosure of Medical Records and Case Information Waiver of Confidentiality

I, _____, understand that the information contained in my medical and DCFS case record is confidential. However, I give my consent for _____ to release to _____ information indicated in this form as well as copies of my medical records.

This information is to be disclosed for the specific purpose of: _____

This consent is subject to written revocation at any time except to the extent that action has already been taken upon this consent. This consent will automatically expire _____ .
(60 days)

_____ _____
Signature of Patient/Applicant Date

_____ _____
Witness Witness

Case: _____ Hospital ID #: _____

SSN: _____ Date of Birth: _____

Address: _____ Dr.'s Name: _____

_____ Dr's Address: _____

Caseload: _____ Dr's. Phone #: _____

Race _____ Sex _____

Persons receiving cash assistance through DCFS are subject to a time-limited benefit program and are required to participate in our agency's work/training/education program. Our goal is to strengthen families by assisting them to become self sufficient through employment or permanent income. Your expert opinion is needed in assisting this patient with proper training and employment goals that take into consideration what he/she is capable of doing. Considering our goal, please complete the requested information.

The previous medical information submitted on this patient is dated _____. Please provide updated information on the patient's condition as well as prognosis for recovery and ability to become employed or trained for employment. This updated information is necessary to determine continued eligibility for assistance. Existing medical records may be provided to supplement this report.

_____ _____
DCFS Representative Contact Number

Case Name: _____

Date last examined: _____ Date first examined: _____

Date of next appointment: _____ Frequency of visits: _____

Number of hospitalizations in last 12 months: _____

Reason:

_____

Current Diagnosis:

_____

What is the patient capable of doing with his/her condition? _____

_____

Current Laboratory Data (CBC, Urine, X-ray, EKG, etc.) (Include Dates):

A. EKG Report _____
B. Report of any X-Ray _____
C. Other pertinent lab data _____
D. Blood pressure readings _____
E. Blood glucose levels _____

Is patient on medication? _____ Yes _____ No

Name of Medication	Dosage/How Often Taken

Able to sit in an air/heat controlled environment in a class oriented activity:

_____6 hours per day/5 days per week _____hours per day _____days per week _____not capable

May he/she return to work? Full time?_____Yes _____No Part Time _____Yes _____No

Are there any restrictions? _____

_____

_____

Recommended training or type of work for patient's current condition: _____

_____

_____

Expected duration of condition: _____ through _____
Begin Date End Date

Please circle when update is recommended: 3 mos 6 mos 9 mos 12 mos

_____ _____
Signature of Examining Physician Date