

**COMPREHENSIVE MEDICAL REPORT (A)**

Note to Physician: The following information is for use in connection with the applicant/member's application. Please make your report **COMPLETE** and **LEGIBLE** to allow the reviewer to determine accurately the nature and severity of impairment.

Applicant/Member's Name (Last, First, Middle) _____
D/O/B _____ Sex _____ Marital Status _____

1. Physical Measurements: Height: _____ Weight: _____

2. HISTORY:

A. Past Medical History:

B. Onset date of present illness or injury _____

C. Is there a previous history of this illness? _____ If "YES", describe _____

3. PRESENT CONDITION (ALL MAJOR IMPAIRMENTS)

A. Subjective Symptoms: _____

B. Objective Findings: (Give report of X-rays, lab, diagnostic tests, etc. with dates. Use separate sheet if necessary)

C. Applicant is: Ambulatory _____ Confined to: Wheelchair _____ Bed _____ Home _____ Hospital _____

D. Mental Status: _____

4. DIAGNOSES: _____

5. PROGNOSIS: _____

6. REHABILITATION and /or MAINTENANCE GOALS: _____

7. TREATMENT:

A. Therapy and response: _____

B. Date of first visit: _____ Frequency of visits: _____

C. Date when you last examined this applicant/member: _____

D. Diet: _____

E. Medications: _____

F. Recommended Activities: _____

8. PROGRESS: Applicant/member's condition is:

Improving _____ Static _____ Deteriorating _____ Terminal _____

Remarks: _____

Meets a Nursing Home Level of Care for Care in a Facility or Community: __YES__ __NO__

Physician's Name _____

Physician's Address _____

Physician's Signature _____ Date _____