Medical Examination and Capacity

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

The provision of your Social Security Number (SSN) is mandatory under Wisconsin Statutes 49.145 (2)(k). Your SSN may be verified through computer matching programs and may be used to monitor compliance with program regulations and program management. Your SSN may be disclosed to other Federal and State Agencies for official examination. If you do not provide your social security number, your application for benefits will be denied.

Participant Name	Date of Birth	Social Security Number
	/ /	

Name of Professional Provider	Professional Title

Office Address	City	State	Zip Code

Dear Health Professional,

The individual named above is an applicant/participant in the **Wisconsin Works (W-2)** program. The purpose of this form is to gather information about this individual's current ability to participate in W-2 activities.

W-2 is a program designed to help individuals become self-sufficient through work and work readiness activities. In order to assign appropriate activities, it is important for us to have an idea of what tasks and assignments this individual is capable of. It is also important for us to know about accommodations and modifications that may assist this individual in participating in work readiness activities.

Activities that can be a part of a W-2 placement include:

- Job readiness/life skills workshops;
- Education and job skills training;
- On-the-job work experience;
- Recommended medical treatments; and
- Counseling and physical rehabilitation activities.

Please answer the following questions concerning this individual's medical condition(s):

1. How frequently is the patient scheduled to meet with you?

   _____

   Regarding current course of treatment, how long have you been meeting with this patient?

   _____

   When is your next scheduled appointment with this patient?

   _____

2. Are you aware of any other health care professionals who are currently treating this person? If yes, please identify provider name and purpose of treatment:

   _____

3. Diagnosis/Condition: _____

   _____

   _____

4. Prognosis: (If the patient's condition is related to pregnancy, please enter the expected date of birth)

5. When did your patient's symptoms begin (estimate date)?

   Is it likely that your patient's symptoms will last 6 months or longer? ☐ Yes ☐ No

   Is it likely that your patient's symptoms will last 12 months or longer? ☐ Yes ☐ No

6. What kind of treatment plan is the patient involved in? What is the expected outcome?

   If schedule for treatment plan is known, please include below or attach:

7. What type of environment or conditions could help this person function most effectively in a variety of daily activities?

8. This individual may have his/her vocational capacity assessed. What, if any, accommodations should be provided for the assessment?

9. Is the patient attending scheduled appointments? ☐ Yes ☐ No

   If no, please explain and list missed appointment dates:

   Do you attribute the missed appointments to the impairment(s)?

   ☐ Yes ☐ No

10. Identify any psychological conditions that you are aware of:

    ☐ Depression
    ☐ Somatoform disorder
    ☐ Psychological factors affecting physical condition
    ☐ Anxiety
    ☐ Personality disorder
    ☐ Other:

11. **Physical Capacities**

    Maximum ability to lift and carry on an occasional basis (no more than 2 hours out of an 8-hour day).

    ☐ No limitation ☐ 100 lbs. ☐ 50 lbs. ☐ 20 lbs. ☐ 10 lbs. ☐ Other:

    Maximum ability to lift and carry on a frequent basis (no more than 6 hours out of an 8-hour day).

    ☐ No limitation ☐ 100 lbs. ☐ 50 lbs. ☐ 20 lbs. ☐ 10 lbs. ☐ Other:

Maximum ability to stand and walk (with normal breaks) during an 8-hour day.

☐ No limitation ☐ No more than 6 hours ☐ No more than 2 hours ☐ Other: _____

How many city blocks can this individual walk without rest or severe pain? _____

Maximum ability to sit (with normal breaks) during an 8 hour day.

☐ No limitation ☐ No more than 6 hours ☐ No more than 2 hours ☐ Other: _____

For questions 12-14 below, "rarely" means 1%-5% of an eight-hour workday; "occasionally" means 6%-33% of an eight-hour workday; and "frequently" means 34%-66% of an eight-hour workday.

12. How often can this individual perform the following activities?

Activity	Never	Rarely	Occasionally	Frequently
Look down (sustained flexion of neck)				
Turn head right or left				
Look up				
Hold head in static position				
Twist				
Stoop (bend)				
Crouch/squat				
Climb ladders				
Climb stairs				

13. Does this patient have significant limitations with reaching, handling, or fingering? ☐ Yes ☐ No

If yes, please indicate the percentage of time during an 8-hour day that your patient can use hands/fingers/arms for the following activities:

Activity		Never	Rarely	Occasionally	Frequently
Hand: Grasp, turn twist objects	**Right**				
	Left				
Fingers: Fine finger manipulation	**Right**				
	Left				
Arm: Reaching (including overhead)	**Right**				
	Left				

14. If your patient's symptoms interfere with performance of simple work tasks, please estimate the frequency of interference?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

15. What is your assessment of this individual's ability to communicate and see?

_____

_____

16. Is your patient making positive progress? ☐ Yes ☐ No

Please describe the progress or lack of progress.

_____

_____

17. Are the patient's impairments likely to produce 'bad' days? ☐ Yes ☐ No

If yes, on the average, how often do you anticipate that your patient's impairments would become acute so that the patient would be absent from work and/or other W-2 activities?

☐ Once per month or less
☐ About twice per month
☐ Over twice per month
☐ More than 3 times per month

18. Does this person's medication(s) or treatment cause side effects that impact his/her ability to participate in a work/education environment (e.g., drowsiness, dizziness, nausea, etc.)?

☐ Yes ☐ No

If "Yes" specify: _____

19. Does this person require any adaptive devices or other accommodations to help him/her function effectively in a work/education environment (e.g., assistive device for ambulation, need to alternate positions frequently, limits on pushing and pulling, operating hand or foot controls, accommodations for bending and stooping, part-time or flexible work schedule, etc.)?

☐ Yes ☐ No ☐ Unknown

If "Yes" describe what is needed:

_____

20. Identify any of the following that your patient is likely to experience:

☐ Low tolerance for frustration
☐ Difficulty communicating his/her needs
☐ Difficulty following instructions
☐ Inability to work with children
☐ Difficulty working around other people
☐ Difficulty controlling anger appropriately
☐ Socially inappropriate responses to situations
☐ Seizures
☐ Difficulty engaging in complex tasks that require judgment
☐ Difficulty maintaining activities of daily living
☐ Difficulty with decision making
☐ Difficulty following through on agreed actions
☐ Panic attacks
☐ Difficulty with reality interpretation
☐ Difficulty being in unfamiliar environment
☐ Difficulty with impulse control
☐ Difficulty maintaining concentration
☐ Other: _____

21. Please recommend any other activities and services not included in your treatment plan that may help this individual further address his/her mental health impairment:

☐ Assessment (please specify type): _____
☐ Treatment and/or counseling (please specify): _____
☐ Advocacy for Social Security Income/Disability
☐ Other: _____

22. Additional Recommendations or Restrictions: _____

_____

_____

23. Considering this patient's condition(s) and limitation(s) please indicate below what activities related to work and training you would recommend:

☐ Work/work experience activities
☐ Adult basic education/literacy
☐ Job readiness/life skills workshops
☐ Job skills training
☐ Supported job search activities
☐ Other: _____

If no recommendations, please explain:

24. Estimate the number of hours a day (5 days a week) this individual can participate in work/work readiness activities within these recommendations: _____

25. If you have indicated anywhere on this form that this patient is unable to participate in W-2 activities, please explain:

26. Given your patient's current medical condition(s), please specify a date when the recommendations that you have provided should be reviewed:

Name of Professional Provider	Title	Telephone Number
Signature of Professional Provider		Date Signed

Return completed form to:

Name of Agency Representative		Address		Date Sent
City	State	Zip Code	Telephone Number	Fax Number