MAP-252F (face)
06/25/03

Human Resources Administration
Medical Assistance Program

AIDS OR AIDS RELATED COMPLEX MEDICAL REPORT
(Addendum to form LDSS-486T)

a. CLIENT'S NAME	b. SSN
c. DATE OF BIRTH	d. CASE NO

Please answer all the questions relevant to the client's condition based on the information available in your records. A copy of your record may be substituted if it contains the requested information. Original materials will be photocopied and returned to you on your request.

1. DATES OF TREATMENT	FIRST	LAST	FREQUENCY

2. DIAGNOSIS.

3. History and subsequent course including date of first symptoms, description of findings (e.g., fever, weight loss weakness, etc.)

4. Has the patient had any severe opportunistic infections or other AIDS related diseases? How were they confirmed? **Please describe and forward any available confirming biopsy or culture reports.**

5. Findings on **last** examination. Give date _____.

   a) Height (without shoes)_____ b) Weight _____

   c) Current Symptoms (If there is a history of weight loss, please list a series of weights and dates).

   _____

   _____

   d) Clinical findings (e.g., fever, oral thrush, adenopathy, and other abnormalities noted)

   _____

   _____

6. Relevant Laboratory findings with dates and results, e.g., blood studies, x-rays, microscopy cultures, endoscopy, brain imaging, and other special studies, (please send a copy of report).

   a. HIV antibody test _____

   b. Absolute T4 count_____

   c. T4/T8 Ratio_____

   d. Biopsy_____

   e. Any other significant laboratory findings?_____

7. Please give treatment and response, including dosages, side effects, and operative procedures, if performed.

8. Are the patient's daily activities limited by his/her condition?

☐No ☐Unknown ☐Yes, (Please complete the following)

9. Please describe what the patient can do on a daily basis. If activities are limited due to the medical condition, symptoms or any side effects of medication, please describe the reason for the limitation (i.e., "limited by fatigue"; "limited by weakness").

a. Can the patient sustain the following activities over a 6 to 8 hour day, 5 days a week?

Sitting (how long?): _____ Standing (how long?): _____

Walking (how long?): _____ Lifting (how many pounds? Frequency?): _____

Carrying (how many pounds? How far?): _____ Handling objects: _____

b. Please describe any limitations to the patient's ability to hear, speak and see. _____

_____

_____

c. What limitations are there on the patient's ability to travel? _____

_____

d. Does the patient have a mental impairment? If so, please describe his./her ability to:

Understand: _____

Remember and carry out instructions: _____

Respond appropriately to supervisors, co-workers, and work pressures in a work setting: _____

_____

10. Please comment upon any other significant conditions present:

Would you like your original materials returned? ☐Yes ☐No

FACILITY	PHONE
SIGNATURE (M.D)	POSITION
NAME PRINTED (M.D)	DATE