Medical Evidence Worksheet

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| **Name:** |
| **DOB:** | **SSN:** |
|  |
| **Admission Note:** |
| **Source** | Date(s) requested | Date received |
| **Psychosocial Evaluation** |
| **Source** | Date(s) requested | Date received |
| **Psychological Testing** |
| **Source** | Date(s) requested | Date received |
| **Occupational Therapy Evaluation** |
| **Source** | Date(s) requested | Date received |
| **Neurological Assessment** |
| **Source** | Date(s) requested | Date received |
| **Physical Exam** |
| **Source** | Date(s) requested | Date received |
| **Laboratory Results** |
| **Source** | Date(s) requested | Date received |
| **EEG/CT Scan Results** |
| **Source** | Date(s) requested | Date received |
| **Psychiatric Evaluations:** |
| **Source** | Date(s) requested | Date received |
| **Progress Notes that describe functional problems and current symptoms** |
| **Source** | Date(s) requested | Date received |
| **Discharge Summary** |
| **Source** | Date(s) requested | Date(s) requested |