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 |