Social Security Disability Report - Child

The following disability report is to be used for Disability or SSI Benefits for your patient. We understand how valuable your time is, and this data sheet has been designed to allow you to provide medical information in an efficient and organized manner. Your records and medical judgment are vital in determining disability.

Childs Name:_____

Address:_____

City:_____State:_____ZIP_____

Age:_____Birth Date:_____Current Grade in School:_____

1. Does this child have Asthma? ☐ Yes ☐ No

2. Please list all relevant findings and tests that support diagnosis.

3. Will condition last for longer than 12 months? ☐ Yes ☐ No
If yes please explain.

4. Please list current treatment regimen, include all medications and dosages:

5. Please describe significantly limiting therapeutic drug side-effects (e.g. sleepiness, blurry vision, dizziness, etc.) which patient has complained about to you.

6. Has child had attacks occurring during the past twelve months, in spite of prescribed treatment, at least once every two months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for control of asthma counts as two attacks.

☐ NO

☐ Yes … If yes, please provide details and dates of occurrence._____
_____
_____

7. Has child had persistent low-grade wheezing between acute attacks or absence of extended sympthom –free periods requiring daytime and nocturnal use of sympathomimetic bronchdilators with one of the following: ***Please check all below if applicable.***

☐ Persistent prolonged expiration with radiographic or other apporopriate imaging techniques evidence of pulmonary hyperinflation or peribronchial disease.

☐ Short courses of corticosteriods that average more than 5 days per month for at least three months during a twelve month periods.

8. Is childs FEV_1 equal to or less than the value specified below:

Height without Shoes (inches)	FEV_1 equal to or less than (L,BTPS)
46 or less	0.65
47-50	0.75
51-54	0.95
55-58	1.15
59-62	1.35
63-64	1.45
65-66	1.55
67 or more	1.65

If YES, please describe here:

_____

_____

_____

Physician Name:_____

Please Print Above

Physician Signature:_____

Address:_____

City:_____State:_____Zip:_____

Phone: ( )_____Fax: ( )_____

Date Completed:_____