interfaithHOUSE
Restoring health, rebuilding lives, returning home.

SIGNED MEDICAL DIAGNOSIS

Client name: _____

SSN: _____ Date of birth: ____/____/_____

Referring institution: _____

Primary acute diagnosis: _____

Other medical diagnoses: _____

Client has a disability: _____ Yes _____ No Disability type: _____Physical _____ Mental

Based on the patient's medical diagnoses, s/he:

_____ *SHOULD* apply for disability benefits.

_____ *SHOULD NOT* apply for disability benefits.

_____ Patient already has disability benefits.

If the client is impacted by HIV/AIDS, please complete the following:

Date of HIV diagnosis: ____/____/_____

Date of AIDS diagnosis (if applicable): ____/____/_____

Location of HIV/AIDS treatment: _____

CD4 count: _____ Date of test: ____/____/_____

Viral load: _____ Date of test: ____/____/_____

TB test results: _____ Date of test: ____/____/_____

Current status (please check):

____ HIV-Asymptomatic ____ HIV-Symptomatic ____AIDS

Physician's Signature: _____ Date: ____/____/_____

Please fax to (773) 533-9034