



COMPREHENSIVE MEDICAL REPORT (B) AIDS/HIV

Note to Physician: The following information is for use in connection with the applicant/member's application. Please make your report COMPLETE and LEGIBLE to allow the reviewer to accurately determine the nature and severity of impairment.

Applicant/Member's Name (Last, First, Middle) \_\_\_\_\_
D/O/B \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

1. Physical Measurements: Height: \_\_\_\_\_ Weight: \_\_\_\_\_

2. HISTORY:

A. Past Medical History: HIV \_\_\_\_\_ (date diagnosed) AIDS Defined \_\_\_\_\_ (date diagnosed)

B. Onset date of present illness or injury \_\_\_\_\_

C. Is there a previous history of this illness? \_\_\_\_\_ If "YES", describe \_\_\_\_\_

3. PRESENT CONDITION (ALL MAJOR IMPAIRMENTS)

A. Subjective Symptoms: Date: \_\_\_\_\_

- Febrile Night Sweats Fatigue Headaches Vision Change Thrush Difficulty Swallowing
Cough/SOB Chest Pain Nausea/Vomiting Diarrhea Abdominal Pain Appetite Changes
Weight Loss Peripheral Neuropathy Muscle/Joint Pain Skin Rashes/Itching

B. Objective Findings: Date: \_\_\_\_\_ WBC \_\_\_\_\_ HGB \_\_\_\_\_ HCT \_\_\_\_\_ Platelets \_\_\_\_\_
CD4 \_\_\_\_\_ CD4% \_\_\_\_\_ PCR \_\_\_\_\_

C. Applicant is: Ambulatory \_\_\_\_\_ Confined to: Wheelchair \_\_\_\_\_ Bed \_\_\_\_\_ Home \_\_\_\_\_ Hospital \_\_\_\_\_

D. Mental Status: \_\_\_\_\_

4. DIAGNOSES: \_\_\_\_\_

5. PROGNOSIS: \_\_\_\_\_

6. REHABILITATION and /or MAINTENANCE GOALS: \_\_\_\_\_

7. TREATMENT:

A. Therapy and response: \_\_\_\_\_

B. Date of first visit: \_\_\_\_\_ Frequency of visits: \_\_\_\_\_

C. Date when you last examined this applicant/member: \_\_\_\_\_

D. Diet: \_\_\_\_\_

E. Medications: \_\_\_\_\_

F. Recommended Activities: \_\_\_\_\_

8. PROGRESS: Applicant/member's condition is:

Improving \_\_\_\_\_ Static \_\_\_\_\_ Deteriorating \_\_\_\_\_ Terminal \_\_\_\_\_

Remarks: \_\_\_\_\_

Meets a Nursing Home Level of Care for Care in a Facility or Community: \_\_\_\_\_ YES \_\_\_\_\_ NO

Meets an Acute Hospital Level of Care (AIDS/HIV): \_\_\_\_\_ YES \_\_\_\_\_ NO

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_