Dodge Child Support Agency
210 W Center St. Juneau WI 53039

Attn: _____________________
Fax: 920.386.3906

*** **CONFIDENTIAL** ***

Re: ___________________ Case #: _____________

Please complete the following medical information and return this form, along with copies of any notes/reports which will assist **the Child Support Agency** in assessing the patient's ability to work and pay child support.

MEDICAL HISTORY – brief description of problem(s):

____

____

When did the patient's symptoms begin? ________________

PROGNOSIS OF PATIENT:

____

Is the patient attending all scheduled appointments? ☐ Yes ☐ No

LIMITATIONS

Is the patient restricted by a physical or mental health condition? ☐ Yes ☐ No

If yes, please specify____

Can the condition be corrected by treatment/surgery? ☐ Yes ☐ No

What is the expected outcome of this treatment plan?______________________

____

If the patient complies with treatment will they be able to function at their prior capacity? ☐ Yes ☐ No

Is the patient complying with the treatment recommendations? ☐ Yes ☐ No

In your opinion, can patient perform: (check all that apply)

☐ Heavy Work	☐ Full time	_____ Number days/week
☐ Moderate Work	☐ Part time	_____ Hours/day
☐ Light Work		

Is return to previous occupation recommended? ☐ Yes ☐ No

Does your patient's symptoms interfere with performance of simple work task?

☐ Yes ☐ No

Please explain:____

☐ Person is <u>NOT</u> incapacitated

☐ Person is incapacitated until______________(date)

Date of last exam: _______________ Date of next appointment:______________

Date form completed: ________________

Physician's printed name: _____________________________________

Physician's Signature: ____