Polk County Community,
Family & Youth Services
2309 Euclid Ave
Des Moines, IA 50310

General Assistance
Phone: (515) 286-2088
Fax: (515) 323-5220

Medical Incapacity Report

Name of Patient: _____ **DOB:** _____

Address: _____

Patient's Consent to Release Information: I do hereby authorize the release of the results of any examination, including clinical, laboratory or hospital records pertaining to my condition to the Polk County Department of Community, Family & Youth Services, General Assistance Program. ***This authorization expires 60 days after date of signature****

_____ _____

Patient Signature **Date**

The information requested concerning this patient will be used by the Polk County Department of Community, Family & Youth Services to reach a determination concerning the eligibility for emergency assistance. The information you provide will be shared with the client upon request.

Physician's Report:

1. **Diagnosis:** (Physical and/or mental condition. If mental, please include axis.

_____
_____
_____
_____

2. **Treatment**:
   a. Has the patient been under supervision? Yes _____ No _____
   b. What is the probable duration of treatment? _____
   c. When should the patient be re-examined? _____
   d. Is the condition temporary? ( ) Progressive? ( ) Permanent? ( )
   e. What type of treatment is given? _____
      _____
      _____

3. **Work Capacity**:
   a. Present work capacity? _____
   b. What working conditions should be avoided? _____
      _____
   c. Additional Comments: (May use back of form) _____
      _____
      _____
      _____
      _____

_____ _____

Name of Examiner (Print or Type) **Title of Examiner (Print or Type)**

_____ _____ _____

Facility Name **Address** **Phone**

_____ _____ _____

Date of Exam **Date of Report** **Physician Signature** **(MD, DO, ARNP, PA, Licensed Psych, Therapist)**