DSS-486T (Rev. 9/91)

MEDICAL REPORT FOR DETERMINATION OF DISABILITY

Pages 1 and 2 MUST be completed in their entirety by ALL providers.
Subsequent pages must be completed only on the basis of impairment.

NEW YORK STATE — *Please type or print clearly* — DEPARTMENT OF SOCIAL SERVICES

SECTION I - **IDENTIFICATION (To Be Completed by Submitting Agency)**

AGENCY'S NAME AND ADDRESS	PATIENT'S NAME (Last, First, Middle)	CASE NUMBER	
		SOCIAL SECURITY NUMBER	
	PATIENT'S ADDRESS	SEX	DATE OF BIRTH
	CITY · STATE · ZIP CODE	☐ MALE ☐ FEMALE	

SECTION II - **MEDICAL REPORT**

NOTICE TO PHYSICIAN

This patient has made application (reapplication) for Disability Medicaid. Your cooperation in completing the form to show the patient's current condition, focusing on both limitations and remaining capabilities, is requested. Your promptness will insure an early decision on the patient's application. **Please return completed form to the agency in Section I above.**

DATE OF EXAMINATION	1. DIAGNOSIS(ES)

2. CURRENT MEDICATIONS AND DOSAGES

3. GENERAL FINDINGS:

Height	Weight	Blood Pressure
______ Ft. ______ In.	______ Lbs.	

DURATION Has the impairment(s) described above lasted, or can it/they be expected to last for 1 year, or more? ☐ Yes ☐ No

If "No", how long? ______

PATIENT COMPLIANCE Has patient demonstrated compliance with medical treatment? ☐ Yes ☐ No If "No", please state reason. ______

BODY SYSTEMS Please indicate if the systems listed below are "normal"/"abnormal" or "present"/"absent". ("Abnormal" or "present" means patient's complaint, objective physical finding or atypical diagnostic test.) Where "abnormal"/"present" body systems are indicated, please complete the appropriate body system section in detail or submit a summary of your records which contain the required information. Please include operative notes if surgical procedures have been performed.

SYSTEM	NORMAL	ABNORMAL	
Musculoskeletal	☐	☐	See Pg. 3-8
Special Senses and Speech	☐	☐	See Pg. 9-12
Respiratory	☐	☐	See Pg. 13-14
Cardiovascular	☐	☐	See Pg. 15-16
Digestive	☐	☐	See Pg. 17
Genito-Urinary	☐	☐	See Pg. 18
Hemic and Lymphatic	☐	☐	See Pg. 18

SYSTEM	NORMAL	ABNORMAL	
Skin	☐	☐	See Pg. 19
Endocrine	☐	☐	See Pg. 19
Multiple Body	☐	☐	See Pg. 20
Neurological	☐	☐	See Pg. 21
	PRESENT	ABSENT	
Mental Disorders	☐	☐	See Pg. 22-24
Neoplastic Diseases, Malignant	☐	☐	See Pg. 25

FUNCTIONAL CAPACITY

CHART 1 - EXERTIONAL FUNCTIONS

Please indicate ranges of physical exertion possible below by circling the appropriate areas for this patient.

	RANGES OF PHYSICAL EXERTION				
	HEAVY	MEDIUM	LIGHT	SEDENTARY	LESS THAN SEDENTAR'
Lifting	100 lbs. occ. 50 lbs. freq.	50 lbs. occ. 25 lbs. freq.	20 lbs. occ. 10 lbs. freq.	10 lbs/occ.	< 10 lbs. occ.
Standing and/or Walking	6 hrs/day min.	6 hrs/day min.	6 hrs/day min.	2 hrs/day	< 2 hrs/day
	6 hrs/day min.	6 hrs/day min.	6 hrs/day min.	2 hrs/day	< 2 hrs/day
Pushing/ Pulling	N/A	N/A	Arm and/or leg controls	N/A	N/A
Sitting	N/A	N/A	N/A	6 hrs/day	< 6 hrs/day

CHART 2 - NON-EXERTIONAL FUNCTIONS

Please indicate if the below indicated functions are normal or abnormal. If abnormal, please explain limitation in the space provide

SENSORY	NORMAL	ABNORMAL	EXPLANATION
Seeing/Hearing	☐	☐	
Speaking	☐	☐	
POSTURAL	NORMAL	ABNORMAL	EXPLANATION
Repetitive stooping and bending for long periods	☐	☐	
Remaining seated for long periods	☐	☐	
Crouching or Squatting	☐	☐	
Climbing	☐	☐	
MENTAL	NORMAL	ABNORMAL	EXPLANATION
Understanding, carrying out and remembering instructions	☐	☐	
Responding appropriately to co-workers and to supervision	☐	☐	
Meeting quality standards and production norms	☐	☐	
Sustaining adequate attendance	☐	☐	
MANIPULATIVE	NORMAL	ABNORMAL	EXPLANATION
Grasping, releasing, handling and fingering objects	☐	☐	
ENVIRONMENTAL	NORMAL	ABNORMAL	EXPLANATION
Tolerating dust, fumes extremes of temperature	☐	☐	
Tolerating exposure to heights or machinery	☐	☐	
Operating a motor vehicle	☐	☐	

EXAMINING PHYSICIAN

SIGNATURE X ______ M.D. | (PRINT NAME) ______ M.D. | DATE SIGNED

SPECIALTY, IF ANY | BOARD CERTIFIED ☐ Yes ☐ No | BOARD ELIGIBLE ☐ Yes ☐ No

OFFICE ADDRESS | OFFICE TELEPHONE NUMBER

MUSCULOSKELETAL MEDICAL REPORT

Patient's Name ______________________ | **SSN** ______________________

1. **Diagnosis** ______________________

2. **Dates of Treatment** First ______________ Last ______________ Frequency ______________

3. **History and Subsequent Course** Include date and description of earliest symptoms; any history of trauma or joint inflammation, sensory, motor or reflex deficits.

4. **Findings on Last Examination With Date**

   a. Please describe any current findings including presence or absence of muscle spasm, sensory, motor or reflex deficits (including sites), with measurement of atrophy of both affected and unaffected extremity at same level for comparison and any swelling, heat or tenderness. List presence and describe location and severity of any contracture, ankylosis or subluxation.

   b. Please indicate current limitations of motion in involved joints, with date of exam, using the attached "Range of Motion Chart".

5. **Fractures**

   a. If recent fracture(s) present, give date of occurrence, x-ray report findings, treatment course.

   b. Is there clinical union? ☐ Yes ☐ No

   c. Expected date of full weight bearing ______________ If ambulatory, how far can patient ambulate?

   ______________ Is improvement expected? ______________

   d. Upper extremity -- expected date of restored functional use ______________

MUSCULOSKELETAL MEDICAL REPORT (continued)

Patient's Name ______________________ | **SSN** ______________________

6. Laboratory Findings

Laboratory findings including dates and results of serological test; e.g., rheumatoid factors, sedimentation rate, ai tinuclear antibodies, specific findings on x-ray (or a copy of report), enzyme studies, biopsies, and nerve conductio studies.

7. Treatment

Please give treatment including type, date and results of any surgery performed, current medication with dosage an frequency.

8. Orthotics

If an orthotic appliance is being worn, describe and give indication for use and its efficacy.

9. Ambulatory Aides

Does the patient require a cane, walker or wheelchair?

MUSCULOSKELETAL MEDICAL REPORT

Spinal Disorders

Patient's Name ______________________ | **SSN** ______________________

1. **Diagnosis** ______________________

2. **Dates of Treatment** First ____________ Last ____________ Frequency ____________

3. **History and Current Findings**

   a. Date of first symptoms; inciting factor(s); description of character; location and radiation of pain.

   b. Pertinent physical findings

      (1) Site and severity of any sensory, motor, or reflex abnormalities.

      (2) Please indicate limitation of movement of the spine on the attached "Range of Motion Chart".

      (3) Any atrophy including actual circumferential measurements at a stated point above and below the knee or elbow given in inches or centimeters.

4. **Lab Values**

   Laboratory findings, including dates and specific findings on x-ray (or copy of report), myelogram, or electro-diagnostic testing.

____

MUSCULOSKELETAL MEDICAL REPORT

Spinal Disorders (continued)

Patient's Name ______________________ | **SSN** ______________________

5. Treatment

Treatment including date, nature and result of any surgical procedure (please include copies of operative and patholog reports); medications prescribed with dosage, frequency and response.

6. Observation

Results of verifying observation (e.g., how patient gets on and off examining table, whether results of SLR are consis tent in other positions such as sitting, ability to walk on heels or toes, arise from squatting position, etc.).

RANGE OF MOTION CHART

Patient's Name ______________________ | **SSN** ______________________

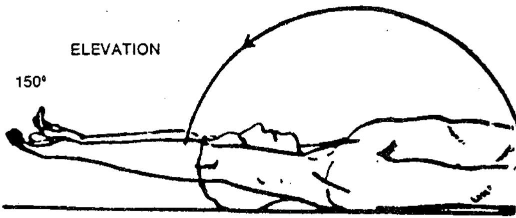
Diagnosis ______________________

Please complete **ONLY** the sections of this chart which illustrate joints that have less than full range of motion. Proceed by filling in the degree at which motion stops. Sections left blank will be considered normal.

SHOULDER

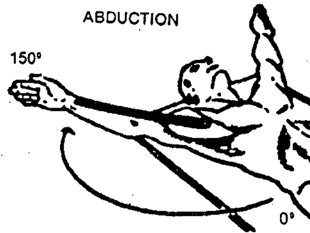
A. Forward Elevation (0°-150°)

Right _______ Left _______



B. Abduction (0°-150°)

Right _______ Left _______



C. Adduction (0°-30°)

Right _______ Left _______

D. Internal Rotation (0°-40°)

Right _______ Left _______

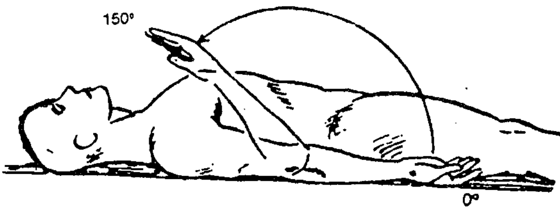
E. External Rotation (0°-90°)

Right _______ Left _______

ELBOW

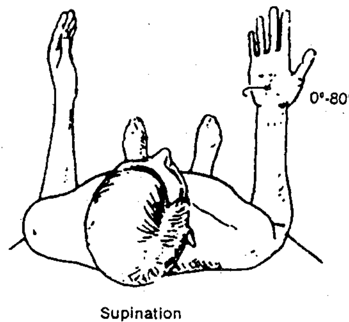
A. Flexion-Extension (0°-150°)

Right _______ Left _______



B. Supination (0°-80°)

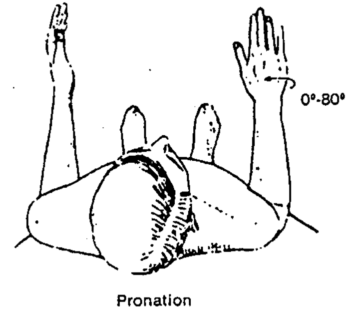
Right _______ Left _______



Supination

C. Pronation (0°-80°)

Right _______ Left _______

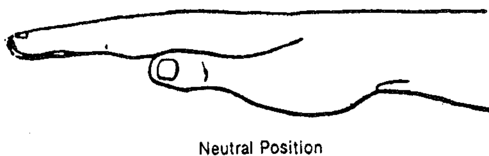


Pronation

WRIST

A. Dorsiflexion (0°-60°)

Right _______ Left _______



Neutral Position

B. Palmar Flexion (0°-70°)

Right _______ Left _______

C. Radial Deviation (0°-20°)

Right _______ Left _______

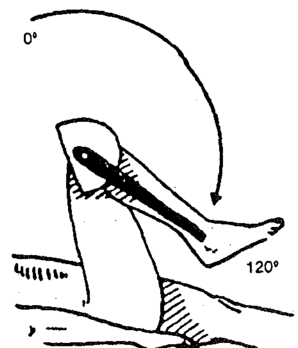
D. Ulnar Deviation (0°-30°)

Right _______ Left _______

KNEE

A. Flexion-Extension (0°-120°)

Right _______ Left _______



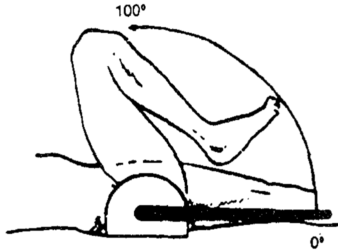
RANGE OF MOTION CHART (Continued)

Patient's Name ______________________ | SSN ______________________

HIP

A. Forward Flexion (0°-100°)

Right _______ Left _______

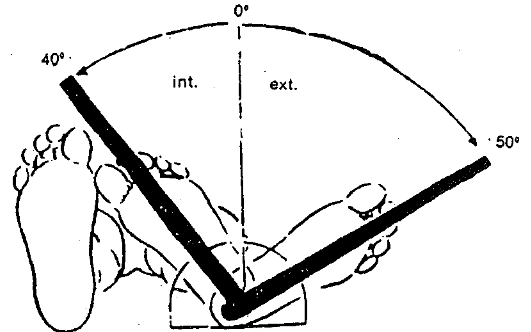


C. Rotation-Interior (0°-40°)

Right _______ Left _______

Rotation-Exterior (0°-50°)

Right _______ Left _______



B. Backward Extension (0°-30°)

Right _______ Left _______

D. Abduction (0°-40°)

Right _______ Left _______

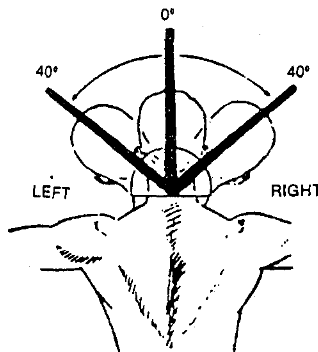
E. Adduction (0°-20°)

Right _______ Left _______

SPINE (Cervical Region)

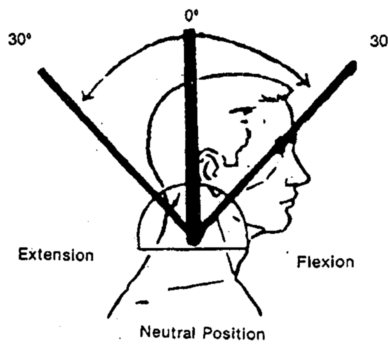
A. Lateral Flexion (0°-40°)

Right _______ Left _______



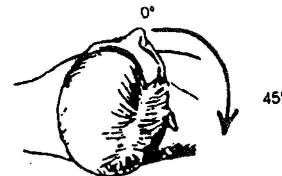
B. Flexion (0°-30°)

C. Extension (0° - 30°)



D. Rotation (0°-45°)

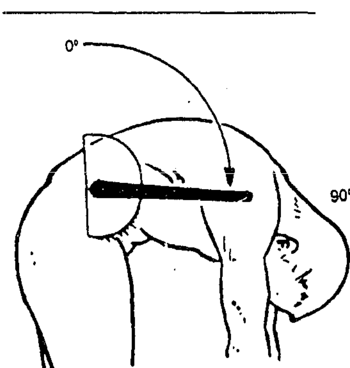
Right _______ Left _______



SPINE (Lumbar Region)

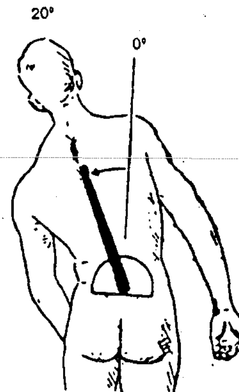
A. Flexion-Extension (0°-90°)

____



B. Lateral Flexion (0°-20°)

Right _______ Left _______



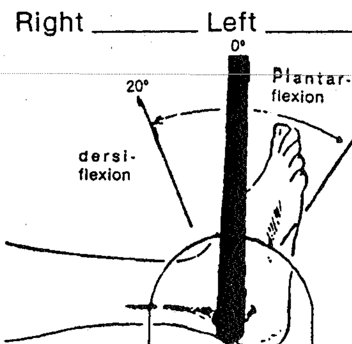
ANKLE

A. Dorsi-Flexion (0°-20°)

Right _______ Left _______

Plantar-Flexion (0°-40°)

Right _______ Left _______



VISUAL MEDICAL REPORT

Patient's Name ______________________ | **SSN** ______________________

1. **Diagnosis**

	Right Eye	**Left Eye**
	______________	______________
	______________	______________

2. **Dates of Treatment** First ______________ Last ______________ Frequency ______________

3. **History:**

	Right Eye	Left Eye
a. Etiology of impairment and signs and symptoms on first visit	______________	______________
	______________	______________
	______________	______________
	______________	______________
	______________	______________
	______________	______________
b. Central visual acuity on first visit		
1. Distant vision without correction	______________	______________
2. Distant vision with best correction	______________	______________
3. Near vision using Jaeger notation	______________	______________
c. Tension	______________	______________

4. **Please give treatment and response, including dates, description, and residuals of any surgical procedures.**

VISUAL MEDICAL REPORT (continued)

Patient's Name ____________________	**SSN** ____________________

5. Current Findings

	Right Eye	**Left Eye**
a. Current signs and symptoms	____________	____________
	____________	____________
	____________	____________
	____________	____________
	____________	____________
b. Central visual acuity Date ____________		
(1) Distant vision without correction	____________	____________
(2) Distant vision with best correction (include power of correcting lenses)	____________	____________
(3) Near vision using Jaeger notation	____________	____________
c. Tension	____________	____________

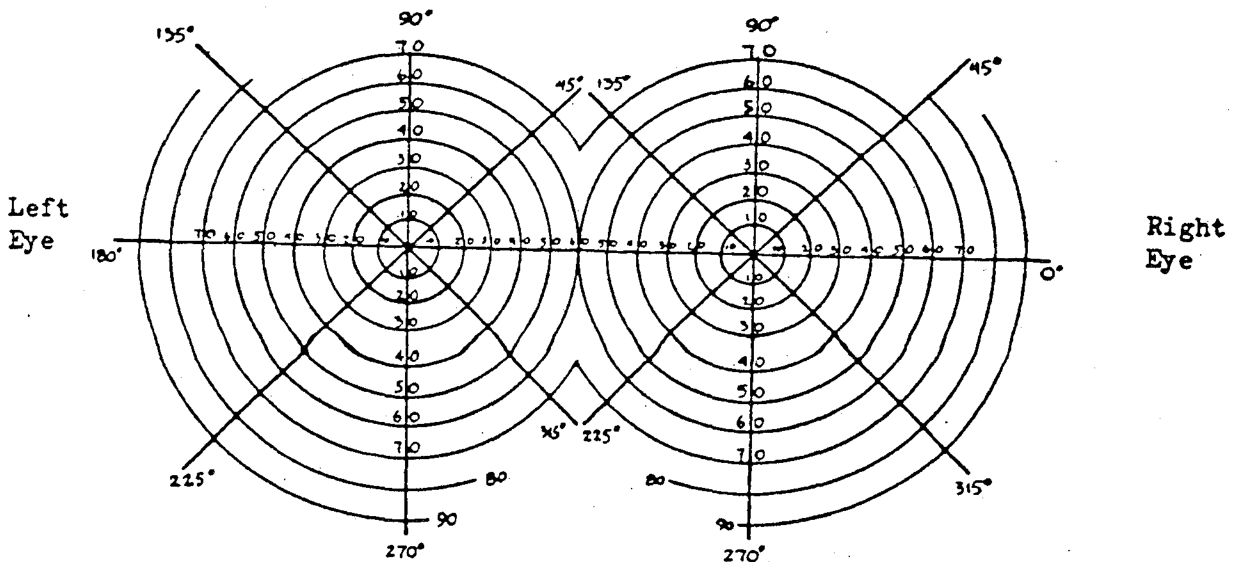
d. If best corrected vision in both eyes is 20/200 or less, specify earliest date of this finding. ____________

e. If visual field is constricted to 10° or less from the point of fixation, or the widest angle subtended to 20° or less, specify earliest date of this finding. ____________

6. Please enclose a copy of results of peripheral visual field testing by arc perimetry or Goldmann projection perimetry or complete the chart below.

a. Date of testing ____________ b. Type and size of target ____________

c. Test distance ____________ d. Illumination ____________ e. Corrective lenses used ☐ Yes ☐ No



HEARING IMPAIRMENT MEDICAL REPORT

Patient's Name ______________________ **SSN** ______________________

1. **Diagnosis** ______________________

2. **Dates of Treatment** First ____________ Last ____________ Frequency ____________

3. **Please give findings on initial and most recent otolaryngological examination.**

4. **Please give results of pure-tone air and bone audiometry requested below. Please include the audiogram or a copy of it.**

   Tested by ☐ Audiologist
   ☐ Otolaryngologist

   a. Audiometer used ______________________

   b. Results in decibels at the following frequencies:

	Left Ear	Right Ear
1. 500 HZ	______	______
2. 1000 HZ	______	______
3. 2000 HZ	______	______

5. **Please give results of speech discrimination testing with best correction**

   a. Test used ______________________

   b. Percentage score ______________________

   c. Decibel level at which testing was done ____________ db.

   d. Speech reception threshold

      1. Left ____________ db.

      2. Right ____________ db.

   e. Results of tympanometry

   f. Hearing aid evaluation

HEARING IMPAIRMENT MEDICAL REPORT (continued)

Patient's Name ______________________ | **SSN** ______________________

6. Please give pertinent laboratory and x-ray findings. In cases of labyrinthine-vestibular disturbance, please give pos tional and caloric testing, electronystagmography, if performed.

7. In cases involving labyrinthine-vestibular disturbance, please answer the following:

a. Is vertigo present? ☐ No ☐ Yes If yes, give:

1. Frequency of attacks ______________________
2. Severity of attacks ______________________
3. Duration of attacks ______________________
4. Activities which precipitate attacks ______________________

____

b. Is there tinnitus? ☐ No ☐ Yes Frequency ______________________

c. Is gait affected? ☐ No ☐ Yes Describe ______________________

____

d. Other symptoms (e.g., headaches, nausea and vomiting, syncope, increased deafness, immobility, etc.)

____

8. Is there evidence of speech impairment? If yes, please describe.

9. Please indicate treatment plan and response.

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RESPIRATORY MEDICAL REPORT

Patient's Name ______________________________ | **SSN** ______________________

1. **Diagnosis** ____

2. **Dates of Treatment** First ____________________ Last ____________________ Frequency ____________________

3. **History.** Include date and description of earliest symptoms (e.g., dyspnea, cough, hemoptysis, weight loss, etc.), and the nature, frequency and duration of episodes of respiratory distress. Include number of acute episodes which have occurred in the past year (with dates) requiring intensive hospital or emergency room care with intravenous or inhalation therapy.

4. **Physical Findings**

   a. Date of Exam ____________________ b. Height ____________________ c. Weight ____________________

   d. Findings on examination (e.g., presence of wheezing, rales, rhonchi, cyanosis, clubbing, edema of extremities, etc.)

   e. Please indicate degree of orthopnea. How many blocks can patient walk or flights of stairs climb without dyspnea?

RESPIRATORY MEDICAL REPORT (continued)

Patient's Name ______________________ | **SSN** ______________

5. **Laboratory Findings with Dates**

Has client had PFT done? ☐ No ☐ Yes If yes, please submit copy or give values as indicated below

a. Results of ventilatory studies (FEV-1, MVV, VC) before and after bronchodilators or copy of report. Please enclose actual spirographic tracings, and comment upon patient's cooperation.

b. Results of chest x-ray, bronchoscopy, blood gas studies (arterial PCO_2 and PO_2)

6. **Please give treatment response**

a. Date and description of any surgical procedure(s) with results

b. Names and dosages of any medications prescribed including dates prescribed and if patient still on prescribed medication

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CARDIOVASCULAR MEDICAL REPORT

Patient's Name ______________________ | **SSN** ______________________

1. **Diagnosis** ______________________

2. **Dates of Treatment** First ____________ Last ____________ Frequency ____________

Please give history including initial symptoms with dates first experienced, associated findings, present symptoms diagnosis (with AMA classification if possible).

3. **Description of Chest Pain**

   a. Location of pain ______________________

   b. Characteristics of pain (e.g., burning, crushing, sticking) ______________________

   c. Site(s) of any radiation of pain ______________________

   d. What precipitates pain ______________________

   e. How pain is relieved ______________________

   f. Duration of episodes ______________________

   g. Frequency of episodes ______________________

   h. Is patient awakened from sleep because of pain? ____________

CARDIOVASCULAR MEDICAL REPORT (continued)

Patient's Name ______________________________ | SSN ____________________

4. Please give positive and pertinent negative findings regarding subsequent course and most recent examination ir cluding dates, several blood pressure readings, funduscopic findings, heart rate, heart sounds, evidence of congestiv heart failure or peripheral vascular disease.

5. Please give treatment and response including dates of any hospitalizations, surgical procedures, medications witl dosages and frequency.

6. If a stress test was performed, state date and protocol used; summarize the treadmill findings; indicate if 85% o the submaximal heart rate was attained. If test was aborted, give the reason, including stage and time in stage, tes was stopped (or submit copy of report).

7. Please enclose labeled copies of EKG'S on which diagnosis is based, giving standardization. Also include any perti nent holter monitor reports.

8. Please give laboratory findings with dates including chest x-ray, angiography and catheterization or echocardiographic reports. In cases of peripheral vascular disease, please give results of arteriography, Doppler or plethysmography o scans if performed (or submit copy of report).

9. Is surgery contemplated? If so, when? ______________________________

DIGESTIVE MEDICAL REPORT

Patient's Name ______________________ | SSN ______________________

1. Diagnosis ______________________

2. Dates of Treatment First ____________ Last ____________ Frequency ____________

3. Please indicate if recurrent upper GI hemorrhage is evident, with etiology. Please indicate dates and results of repeate hematocrits.

4. If peptic ulcer disease is evident, please indicate what has been demonstrated by x-ray or endoscopy.

5. If weight loss has occurred, please describe pattern.

6. If chronic liver disease is evident, please indicate what procedures have been done. Please indicate bilirubin X 5 montl period.

7. If chronic colitis or regional enteritis are present, please give history, including operative findings, barium studies biopsy, endoscopy report findings. Please indicate dates and results of repeated hematocrits. Indicate frequency o episodes of diarrhea, dehydration, pain and hospitalizations. If patient is being treated medically, please indicate medica tions. If being treated with Prednisone, indicate dosage and frequency.

8. Please give any pertinent lab data not included above.

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GENITO-URINARY MEDICAL REPORT

Patient's Name ______________________ | **SSN** ______________________

1. **Diagnosis**______________________
2. **Dates of Treatment** First ____________ Last ____________ Frequency ____________
3. **Please indicate if there is impairment of renal function including history of dialysis (acute or chronic) with frequency transplant procedure report with post-op status report, serum creatinine for three month period. Is nephrotic syndrome present? Please indicate serum albumin and proteinuria.**
4. **Please indicate if anorexia exists and describe weight loss pattern.**

HEMIC AND LYMPHATIC MEDICAL REPORT

Patient's Name ______________________ | **SSN** ______________________

1. **Diagnosis**______________________
2. **Dates of Treatment** First ____________ Last ____________ Frequency ____________
   Please indicate chemotherapeutic treatment regimen.
3. **History and Current Findings**
   a. In cases of chronic leukemia, chronic anemia, macroglobulinemia or heavy chain disease, please indicate hematocrit values from date of diagnosis forward.

   b. In cases of chronic anemia, chronic thrombocytopenia, hereditary telangiectasia, coagulation defects, chronic leukemia, macroglobulinemia, please indicate transfusion history.

   c. If any other cases of hemic or lymphatic disorders exist, please give history and lab values from diagnosis date forward.

SKIN DISORDERS MEDICAL REPORT

Patient's Name ______________________ | **SSN** ______________________

1. **Diagnosis** ______________________
2. **Dates of Treatment** First ____________ Last ____________ Frequency ____________
3. **History and Current Findings**

4. **Please indicate prognosis**

ENDOCRINE MEDICAL REPORT

Patient's Name ______________________ | **SSN** ______________________

1. **Diagnosis** ______________________
2. **Dates of Treatment** First ____________ Last ____________ Frequency ____________
3. **History and Current Findings**

   a. In cases of diabetes, please give complete history of episodes of acidosis, neuropathy, retinopathy and amputation

   b. For all other endocrine disorders, please include diagnostic results and course to date.

MULTIPLE BODY SYSTEMS MEDICAL REPORT

Patient's Name ______________________________ **SSN** ______________________

1. **Diagnosis** ____

2. **Dates of Treatment** First ______________ Last ______________ Frequency ______________

3. **History and Current Findings**

Please indicate the history and current findings regarding the following diagnoses: Hansen's disease; polyarteritis or periarteritis nodosa; systemic lupus erythematosus; scleroderma or progressive systemic sclerosis; obesity. Please include lab values and in cases of obesity, please indicate the following: weight hx, hx pain and limitation of ROM with x-ray reports, blood pressure readings, cardiac status if abnormal, pulmonary function studies if respiratory status is abnormal.

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NEUROLOGICAL MEDICAL REPORT

Patient's Name ______________________________ SSN ______________________________

1. Diagnosis ______________________________

2. Dates of Treatment First ______________ Last ______________ Frequency ______________

3. Please give original chief complaint with initial history and findings.

4. Please describe subsequent course, including dates and details of any hospitalizations; give treatment with date started, response, any surgical procedures performed, medications with dosages.

5. Please give detailed findings on last examination including site and severity of any sensory, motor, reflex, cerebellar, proprioceptive or cranial nerve deficits. Describe the effect upon gait, station, gross and dexterous movements. Are there any difficulties with communication?

6. Please give dates and results of significant laboratory findings (e.g., EEG, LP, brain scan, CAT scan, x-ray or pathology reports, angiogram, etc.); if possible, please append copies of reports.

7. Please indicate prognosis.

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PSYCHIATRIC MEDICAL REPORT

Patient's Name ______________________________ | **SSN** ______________________________

1. **Diagnosis** (including history, with date(s) of hospitalization(s), findings on initial comprehensive mental status exam, diagnosis according to APA terminology per DSM III. If dx of MR is given, please indicate I.Q. test results and name of test administered.)

2. **Dates of Treatment** First ______________ Last ______________ Frequency ______________

3. **Clinical Course** (including type of treatment, names and dosages of any drugs prescribed, response to treatment)

4. **Date (______________) and description of most recent mental status exam to include a full description of the following, together with examples:**

   a. Attitude, appearance, behavior

   b. Speech, thought organization, thought content

   c. Mood and affect

Patient's Name ______________________ | **SSN** ______________________

d. Sensorium and intellectual functions

- attention and concentration
- orientation
- memory
- information
- ability to perform calculations, serial sevens, etc.

e. Insight and judgment

5. Please provide the results of any special testing performed (EEG, psychometric tests, etc.) as well as any informatior you may have concerning other medical impairments.

6. Current Functional Assessment

a. Activities of daily living (Please include a full description of how the patient spends a typical day with specific examples of grooming and hygiene, maintenance of residence, shopping, cooking, taking public transportation interests and hobbies, etc.)

b. Social functioning (Please include a full description with specific examples of capacity to interact appropriatel) and communicate effectively with family members, friends, neighbors, etc.)

PSYCHIATRIC MEDICAL REPORT (continued)

Patient's Name ______________________ | **SSN** ______________________

7. **Ability to Function in a Work Setting.** Please describe in detail any difficulties in work or work-like settings (e.g. volunteer work, workshops, service in community groups), especially with regard to relationships with supervisor, relationships with peers and performance of job duties, (e.g., capacity to understand, carry out and remember instructions).

8. **If suicidal features are present, describe in detail, and include whatever management steps have been taken.**

9. **Other Comments**

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NEOPLASTIC MEDICAL REPORT

Patient's Name ______________________ **SSN** ______________________

1. **Cancer Diagnosis** ______________________
   a. Staging of primary tumor and location of metastasis ______________________

2. **Treatment**
   a. Surgical - Give date of surgery, type and result ______________________

   b. Non-Surgical ☐ Hormonal ☐ Chemotherapy ☐ Radiation
   ☐ Other (specify) ______________________
   (1) Intention ☐ Curative ☐ Palliative
   (2) Treatment Plan
   a. Date initiated ______________________
   b. Specifics - type(s), dosages and frequency administration of agents being used in therapy ______________________
   c. Route given ______________________
   d. Expected duration of each mode of therapy ______________________

   c. Please indicate life expectancy of patient ______________________

3. **Describe any adverse effects of therapy and extent to which it limits patient** ______________________

4. **Patient's Present Status** **Date Last Seen** ______________________
   ☐ No evidence of disease
   ☐ Disease present but not progressing
   ☐ Disease not controlled
   ☐ Other Comments ______________________

   a. Give present clinical and/or laboratory findings ______________________

5. **Give any other diagnoses known with the clinical and laboratory findings available** ______________________

6. **Some advanced lesions are found to be surgically resectable after initial non-surgical therapy is given. If this is o was the case, or if there are any other unusual aspects, please describe** ______________________