UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
JUDGE JAMESON FED BLDG, RM 101
2900 FOURTH AVE NORTH
BILLINGS, MT 59101-1266
E-MAIL: billings@rrb.gov

Form Approved
OMB No. 3220-0038

OFFICE HOURS: M--F 9:00 AM TO 3:30 PM
CLOSED FEDERAL HOLIDAYS

TOLL-FREE NUMBER: 1-877-772-5772
FACSIMILE NUMBER: 1-406-247-7379

Zip code not valid!

Doctor

In reply refer to
RR Employee:
RRB Claim No.:

The patient named above has filed for disability benefits with the Railroad Retirement Board (RRB).

The RRB must make an independent determination of disability based on medical evidence of the patient's impairment. Because we feel that you, as a treating physician, are the best source for this information, we request that you submit a copy of your office records on the claimant's treatment for at least the last 12 months. Also, include copies of all available laboratory, hospital, and consultative reports.

In addition to the copies of your office records, complete the enclosed Form G-250, *Medical Assessment*.

Providing this information is essential for the RRB to determine your patient's entitlement to benefits.

Your cooperation in this matter is greatly appreciated and will assist us in evaluating this claim for disability benefits in a timely manner.

Return the enclosed form along with this cover letter to the address shown above within 20 days from the date you receive this letter.

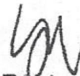
This is not an authorization to conduct a new examination.

James C Mills
A 221-52-3482

Since claimants are responsible for presenting medical evidence on their own behalf from the personal physicians, **any fee that may result from completion of this report is a personal matter between the claimant and you.**

Authorization to release medical information is enclosed.

Sincerely,



Becky Harris
District Manager

Enclosures
Form G-250
Form G-197

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

The Railroad Retirement Board's authority for requesting this information is Section 7 (b)(6) of the Railroad Retirement Act. While you are not required to respond, your cooperation is needed to provide information necessary to complete processing for the claimant named and to determine the claimant's entitlement to disability benefits under the Railroad Retirement Act.

We estimate that this form takes an average of 10 minutes to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed information. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to Chief of Information Resources Management, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-2092.

United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0038

MEDICAL ASSESSMENT

SECTION 1 - Instructions

Some items on this form will not apply to you and you will not need to answer them. Based on your answer to a question, you may be told to skip to another item number, or even another section. Follow the instructions that tell you to "Go to" another item. These are designed to save you time and help you move through this Medical Assessment quickly, filling in only necessary information. If no "Go to" instructions are given, answer the next item in order. Do not skip any items unless directed to do so. Enter "NA" for not affected or "UNK" for unknown, as appropriate.

Please read the Important Notices on page 7.

SECTION 2 - Patient Identification

Railroad Retirement Claim Number	
Social Security Number	
Name	
Address	
Telephone Number	( ) -

SECTION 3 - General Information

		Month	Day	Year
1	Enter the date you began treating the patient.			
2	Enter the date of the last examination.			

3	Enter the patient's weight and height.	____________ Weight ____________ Height

SECTION 4 - Musculoskeletal System

4	A	Enter an "X" in the appropriate box: Is the musculoskeletal system normal?	☐ YES - Go to Section 5 ☐ NO - Go to Item 4B
	B	Describe the impairment. **Attach a copy of any x-ray reports, MRI reports, CT scan reports, etc.**	
5	A	Enter an "X" in the appropriate box: Is there a limitation of motion in the spine or any joints?	☐ YES - Check this box then go to Item 5B and enter either: • the range of motion or • an "N" for normal range of motion ☐ NO - Check this box then go to Item 6

5 B

CERVICAL SPINE	Normal Degrees	Actual Degrees
Flexion	45	
Extension	45	
Right Lateral Flexion	45	
Left Lateral Flexion	45	
Right Rotation	60	
Left Rotation	60	

DORSOLUMBAR SPINE	Normal Degrees	Actual Degrees
Flexion	90	
Extension	30	
Right Lateral Flexion	30	
Left Lateral Flexion	30	

SHOULDER		Right	Left
Abduction	150		
Forward Elevation	150		
Internal Rotation	80		
External Rotation	80		
ELBOW			
Flexion	150		
Extension	0		
Supination	80		
Pronation	80		
WRIST			
Dorsi-Flexion	60		
Palmar-Flexion	70		

HIP		Right	Left
Abduction	40		
Adduction	20		
Flexion	100		
Extension	30		
Internal Rotation	40		
External Rotation	50		
KNEE			
Flexion	150		
Extension	0		
ANKLE			
Dorsi-Flexion	20		
Plantar-Flexion	40		

6 Enter an "X" in the appropriate box:

Are there paraspinal muscle spasm present on examination?

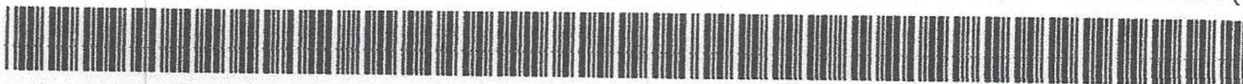
☐ YES
☐ NO

7 Describe muscle strength on a graded scale.

8 Describe any sensory or reflex abnormalities.

9 A Describe, in detail, the patient's gait and station.

9	B	Enter an "X" in the appropriate box: Does the patient walk with an assistive device?	☐ YES - Go to Item 9C ☐ NO - Go to Item 10
	C	How far can the patient walk without using an assistive device?	
10	A	Enter an "X" in the appropriate box: Are there any abnormalities in the patient's hands or fingers?	☐ YES - Go to Item 10B ☐ NO - Go to Section 5
	B	Describe any restrictions in the patient's ability to perform gross and fine manipulations. For example, can the patient pick up a pencil or turn a door knob, etc.? Quantify grip strength on a graded scale.	
SECTION 5 - Cardiovascular System			
11	A	Enter an "X" in the appropriate box: Is the cardiovascular system normal?	☐ YES - Go to Section 6 ☐ NO - Go to Item 11B
11	B	Describe the impairment. Provide any signs of decompensation (edema, cyanosis), etc. Describe any chest pains including character, location, radiation, frequency, duration, precipitating factors, relieving factors, and associated symptoms. **Attach a copy of any EKG tracings, x-ray reports, etc.**	
12		Describe any signs of congestive heart failure.	



	Describe any rhythm disturbances.
13	Describe any rhythm disturbances.
14	Describe any evidence of arterial or venous insufficiency (e.g., intermittent claudication, pulse deficits, brawny edema, etc.).

SECTION 6 - Respiratory System

15	A	Enter an "X" in the appropriate box: Is the respiratory system normal?	☐ YES - Go to Section 7 ☐ NO - Go to Item 15B
	B	Provide detailed objective findings. **Attach a copy of any pulmonary function test (including tracings), x-ray reports, or sputum culture results.**	

SECTION 7 - Neurological System

16	A	Enter an "X" in the appropriate box: Is there a neurological impairment?	☐ YES - Go to Item 16B ☐ NO - Go to Section 8
	B	Describe, in detail, any abnormal neurological findings.	
17		Describe the character, the frequency of attack and the response to medication of any convulsive or seizure disorder.	

SECTION 8 - Vision/Hearing/Speech

18	A	Enter an "X" in the appropriate box: Is the patient's vision, hearing, and speech normal?	☐ YES - Go to Section 9 ☐ NO - Go to Item 18B
	B	If there is a **vision impairment**, provide information about any deficiency in central visual acuity (before and after correction), peripheral visual fields, or other function. **Attach a copy of the visual field charts.**	
	C	If there is a **hearing impairment**, describe the limitations in the patient's hearing. **Attach a copy of any audiometric charts.**	
	D	If there is a **speech impairment**, describe any abnormalities in the patient's speech.	

SECTION 9 - Mental Functions

19	A	Enter an "X" in the appropriate box: Does the patient have a severe mental impairment?	☐ YES - Go to Item 19B ☐ NO - Go to Section 10
	B	Describe the impairment, including emotional reactions, conduct disturbances, orientation, insight, judgment, hallucinations, delusions, memory for recent and remote events, and evidence of mental deterioration. Note any changes in the patient's normal activities of daily living. List medication(s) and response.	

SECTION 10 - Other Systems and Impairments

20	A	Enter an "X" in the appropriate box: Are there any impairments in other systems?	☐ YES - Go to Item 20B ☐ NO - Go to Section 11
	B	Describe the impairment and provide any relevant findings.	

SECTION 11 - Exertional Restrictions

21	A	Enter an "X" in the appropriate box: Are there any exertional restrictions?	☐ YES - Go to Item 21B ☐ NO - Go to Section 12
	B	Describe, in detail, any type of exertional restriction (e.g., limitations on lifting, standing, walking, sitting, stooping, crouching, climbing, etc.)	

SECTION 12 - Environmental Restrictions

22	A	Enter an "X" in the appropriate box: Are there any environmental restrictions?	☐ YES - Go to Item 22B ☐ NO - Go to Section 13
	B	Describe any environmental restrictions (e.g., can the patient work around heights, around machinery, walk on uneven terrain, be exposed to dust, fumes, noise, vibration, temperature extremes etc.?).	

SECTION 13 - Certification

With the understanding that section 13 of the Railroad Retirement Act (45 U.S.C. 231l) provides that anyone who makes false or fraudulent statements or claims for the purpose of causing an award or payment under the Railroad Retirement Act is subject to a fine of up to $10,000, or imprisonment of up to one year, or both, I certify that the information I have furnished is correct to the best of my knowledge.

Signature (*This report must be signed. A stamped signature is not acceptable*)	Date
Printed Name and Title	National Provider Identifier
Address and Daytime Telephone Number	Area Code / Telephone Number

Please return this form along with copies of your office records to:

RAILROAD RETIREMENT BOARD
JUDGE JAMESON FED BLDG, RM 101
2900 FOURTH AVE NORTH
BILLINGS, MT 59101-1266

IMPORTANT NOTICES

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

The information requested on this form is authorized by Section 7(b)(6) of the Railroad Retirement Act. While you are not required to respond, your cooperation is needed to provide information necessary to complete processing for the claimant named and to determine the claimant's entitlement to disability benefits under the Railroad Retirement Act.

We estimate this form takes an average of 30 minutes per response to complete, including time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to Chief of Information Resources Management, Railroad Retirement Board, 844 N. Rush Street, Chicago, IL 60611-1275.

COMPUTER MATCHING AND PRIVACY PROTECTION ACT NOTICES

The Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) requires the Railroad Retirement Board to advise you that information you have provided may be used, without your consent, in automated matching programs. These matching programs are a computer comparison of RRB records with records kept by other Federal, state, or local governmental agencies. Information from the programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Activities of Daily Living

Identifying Information	We need information regarding your activities of daily living. The information you provide will help us determine how your condition(s) affect your normal daily living routines and how they have changed from the past. Please answer the questions below to the best of your ability. You may hand write or type your answers. You may also attach additional pages if necessary to complete your answers (please let us know what section if necessary).		
Initiated by: HQ Field	Date	Name	RRB Claim Number

Applicant Name, Address and Telephone Number

Daily Routine	Describe your typical daily routine at this time.

Sleeping and Rest	Describe your sleeping habits – Do you have any trouble sleeping; describe any **changes** in your sleep patterns, what has changed, and when the change occurred; what time do you get up; how do you wake yourself (alarm, naturally, etc.); when do you go to bed; how often do you take naps (if applicable).

Personal Hygiene	Describe your personal grooming habits - How often do you bathe/shower, shave, and change clothes; do you need help with any of the above; describe any **changes** in your personal grooming habits, what has changed, and when this change occurred. Do you need reminding?

Eating and Meal Preparation	Describe your eating habits - What kind of food do you eat *(for example, sandwiches, frozen dinners, soup, full-course meals, etc.)*; describe any **changes** in the way you prepares meals and why and when these **changes** occurred; does anyone help you with meal preparation; if this is a **change**, explain why you need help and when this **change** occurred; describe any cooking accidents since your condition began (have you had any); has the amount of food consumed by you increased or decreased, and, if so, describe why and when the **change** occurred. How has your appetite been affected if applicable?

Housework and Hobbies	Describe your abilities to do housework; do hobbies, and/or odd jobs - What type of housework *(laundry, vacuuming, dusting, mopping floors, washing dishes, etc.)*, hobbies *(reading, listening to radio, watching TV or movies, sports, collecting, church/club organizations, etc.)*, and/or odd jobs *(household repairs, running errands, lawn care, taking out trash, washing the car, mending clothes, etc.)* do you perform; how many hours per day do you spend on housework/hobby/odd job; do you need help doing the housework/hobby/odd job; who does your housework/hobby/odd job if you are unable; how often do you need help; describe any **changes** in the way you do the housework/hobby/odd job, what has **changed**, and when the **change** occurred.

Shopping	Describe your ability to shop – Do you use a shopping list and, if so, do you prepare the list yourself or does someone else prepare it; what do you usually shop for *(food, clothing, books, magazines, medicine, cigarettes, newspaper, etc.)*; where do you shop; how do you get to the store or shop; describe any **changes** in your shopping habits, what has **changed,** and when the **change** occurred.

Transportation	Describe your ability to use transportation – Do you drive; if you do not drive and if this is a **change**, explain why and when this **change** occurred; how do you get around (walk, public transportation, taxi, bicycle, etc.).
Finances	Describe your ability to handle financial matters - How do you handle your money; do you prepare a budget; do you pay their own bills; do you need to be reminded to pay your bills; if your ability to handle money has **changed**, explain what has **changed**, and when the **change** occurred.
Socialization and Entertainment	Describe your entertainment and social activities – Do you visit friends and relatives; how often and for how long do you stay; describe any **changes** in your social visits, what has **changed**, and when the **change** occurred.
Attention and Concentration	Has your condition(s) affected your concentration when reading, watching TV, or listening to the radio? Do you have any memory problems? Explain and provide examples of what has **changed** and when the **change** occurred.

Employment and Work Routine	Describe your ability to perform your past job duties - Did you have trouble getting to work on time and, if so, explain why there was a problem being on time; describe your attendance record; if absent, explain the cause of the absences; were you able to maintain your work routine; did you have the ability to complete all of your daily work; did you have: (1) any problems concentrating at work; (2) any special needs at work such as frequent rest periods; or (3) any trouble getting along with supervisors, coworkers or customers; were there any times you needed to leave work because of your condition; describe any **changes** made to your work duties that affected your job and your ability to adapt to these **changes**.
Additional Information	Enter any additional information that you feel may be relevant about your activities of daily living. If we need any additional information about activities of daily living, who would best be able to give us that information? Provide name, address and telephone number of the person including their relationship to the applicant (i.e., neighbor, brother, spouse, etc).

FOR RRB INTERNAL USE ONLY

Field Representative initials: ____________________

Date Reviewed: ____________________