NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

Disability Questionnaire Continuation Sheet

NAME:

First: _____

Middle: _____

Last: _____

AGENCY/ADDRESS: _____

_____

_____

Case Number: _____

Client ID Number (CIN): _____

Disability ID Number (DIN): _____

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

In order to make a disability determination, current medical evidence is needed to evaluate your physical and/or mental impairments. If you have not seen a medical provider for your impairment(s) within the past 12 months, a consultative exam may be arranged for you by the local agency.

B. Have you seen any other medical provider(s) within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

Please list the name, address, and phone number of all medical providers you have seen for the past 12 months (for example, physicians, nurse practitioners/physician assistants, mental health counselors, physical/occupational/speech therapists, audiologists, etc.). (Continuation sheets are available.)

Name:	Phone Number:	Address:
Reason for seeing::		
Name:	Phone Number:	Address:
Reason for seeing:		
Name:	Phone Number:	Address:
Reason for seeing:		

C. Have you received medical care in a hospital or other health care facility within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

Please list the name and address of all hospitals and other medical facilities at which you have sought treatment in the past 12 months. Continuation sheets are available.)

Name:	Address:
Reason:	
Name:	Address:
Reason:	
Name:	Address:
Reason:	