

FUNCTIONAL LIMITATIONS

(To be completed by the practitioner - Please check all that apply)

Please check the following activities which are significantly limited by the above stated disability(ies) and/or side effects of medication. Indicate the level of severity as mild, moderate or severe for the identified disability(ies).

1 = Mild

2 = Moderate

3 = Severe

Psychological:

Affect

† á ú Ý † ? á & á † v & Ê Awareness

Communication:

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Sensory:

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Visual

Other:

Breathing

Alertness

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Learning:

Attention

Writing

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Mobility:

Ambulation

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Coordination

Balance

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Fine Motor

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† v & á ú Ý

MEDICATIONS

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ADDITIONAL COMMENTS

(Attach additional documentation if needed)

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X Ý " ú á M " & á ú K †

Address: v & " & Ê K †

City: Zip Code:

IMPORTANT NOTICE

Once the practitioner has signed the form, the form fields in part 2 will be locked and can not be
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Please submit completed form to:
Bob Murphy Access Center OR OR
" õ á Ü ú á " † v & " & Ê †, ú á > Ê á & E † L ú Ý † Ê " À á †
v v v h † via email at via fax at
" † Ê õ õ Ü õ ? Ê † + õ Ê > " Æ † [¿ ú " À À À + õ ¿ I Ê Æ](#) (562) 985-7183
L ú Ý † Ê " À á † † & %!