

**MEDICAL REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION**

DOB CODE:

The individual named below has filed an application for a period of disability and/or disability payments. If you complete this form, your patient may be able to receive early payments. (This is not a request for an examination, but for existing medical information.)

**MEDICAL RELEASE INFORMATION**

- Form SSA-827, "Authorization to Release Medical Information to the Social Security Administration," attached.
- I hereby authorize the medical source named below to release or disclose to the Social Security Administration or State agency any medical records or other information regarding my treatment for human immunodeficiency virus (HIV) infection.

CLAIMANT'S SIGNATURE (Required only if Form SSA-827 is NOT attached)

DATE

**A. IDENTIFYING INFORMATION**

MEDICAL SOURCE'S NAME	CLAIMANT'S NAME
CLAIMANT'S SSN	CLAIMANT'S DATE OF BIRTH

**B. HOW WAS HIV INFECTION DIAGNOSED?**

- Laboratory testing confirming HIV infection
- Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

**C. OPPORTUNISTIC AND INDICATOR DISEASES: Please check if applicable.**

**BACTERIAL INFECTIONS**

- 1.  **MYCOBACTERIAL INFECTION** (e.g., caused by *M. avium-intracellulare*, *M. kansasii*, or *M. tuberculosis*), at a site other than the lungs, skin, or cervical or hilar lymph nodes
- 2.  **PULMONARY TUBERCULOSIS**, resistant to treatment
- 3.  **NOCARDIOSIS**
- 4.  **SALMONELLA BACTEREMIA**, recurrent non-typhoid
- 5.  **SYPHILIS OR NEUROSYPHILIS** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
- 6.  **MULTIPLE OR RECURRENT BACTERIAL INFECTION(S)**, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year

**FUNGAL INFECTIONS**

- 7.  **ASPERGILLOSIS**
- 8.  **CANDIDIASIS**, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs
- 9.  **COCCIDIOIDOMYCOSIS**, at a site other than the lungs or lymph nodes
- 10.  **CRYPTOCOCCOSIS**, at a site other than the lungs (e.g., cryptococcal meningitis)

- 11.  **HISTOPLASMOSIS**, at a site other than the lungs or lymph nodes
- 12.  **MUCORMYCOSIS**

**PROTOZOAN OR HELMINTHIC INFECTIONS**

- 13.  **CRYPTOSPORIDIOSIS, ISOSPORIASIS, OR MICROSPORIDIOSIS**, with diarrhea lasting for 1 month or longer
- 14.  **PNEUMOCYSTIS CARINI PNEUMONIA OR EXTRAPULMONARY PNEUMOCYSTIS CARINI INFECTION**
- 15.  **STRONGYLOIDIASIS**, extra-intestinal
- 16.  **TOXOPLASMOSIS** of an organ other than the liver, spleen, or lymph nodes

**VIRAL INFECTIONS**

- 17.  **CYTOMEGALOVIRUS DISEASE**, at a site other than the liver, spleen, or lymph nodes
- 18.  **HERPES SIMPLEX VIRUS** causing mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or disseminated infection
- 19.  **HERPES ZOSTER**, disseminated or with multidermatomal eruptions that are resistant to treatment
- 20.  **PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY**

21.  HEPATITIS, resulting in chronic liver disease manifested by appropriate findings (e.g., persistent ascites, bleeding esophageal varices, hepatic encephalopathy)

#### MALIGNANT NEOPLASMS

22.  CARCINOMA OF THE CERVIX, invasive, FIGO stage II and beyond
23.  KAPOSI'S SARCOMA, with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment
24.  LYMPHOMA of any type (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkins lymphoma, Hodgkin's disease)
25.  SQUAMOUS CELL CARCINOMA OF THE ANUS

#### SKIN OR MUCOUS MEMBRANES

26.  CONDITIONS OF THE SKIN OR MUCOUS MEMBRANES, with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

#### HEMATOLOGIC ABNORMALITIES

27.  ANEMIA (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every 2 months
28.  GRANULOCYTOPENIA, with absolute neutrophil counts repeatedly below 1,000 cells/mm<sup>3</sup> and documented recurrent systemic bacterial infections occurring at least 3 times in the last 5 months
29.  THROMBOCYTOPENIA, with platelet counts repeatedly below 40,000/mm<sup>3</sup>; with at least one spontaneous hemorrhage, requiring transfusion in the last 5 months; or intracranial bleeding in the last 12 months

#### NEUROLOGICAL ABNORMALITIES

30.  HIV ENCEPHALOPATHY, characterized by cognitive or motor dysfunction that limits function and progresses

31.  OTHER NEUROLOGICAL MANIFESTATIONS OF HIV INFECTION (e.g., peripheral neuropathy), with significant and persistent disorganization of motor function in 2 extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station

#### HIV WASTING SYNDROME

32.  HIV WASTING SYNDROME, characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer; or chronic weakness and documented fever greater than 38° C (100.4° F) for the majority of 1 month or longer

#### DIARRHEA

33.  DIARRHEA, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

#### CARDIOMYOPATHY

34.  CARDIOMYOPATHY (chronic heart failure, or cor pulmonale, or other severe cardiac abnormality not responsive to treatment)

#### NEPHROPATHY

35.  NEPHROPATHY, resulting in chronic renal failure

#### INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT 3 OR MORE TIMES IN 1 YEAR

36.  SEPSIS
37.  MENINGITIS
38.  PNEUMONIA (non-PCP)
39.  SEPTIC ARTHRITIS
40.  ENDOCARDITIS
41.  SINUSITIS, radiographically documented

**NOTE:** If you have checked any of the boxes in section C, proceed to section E. If you have any remarks you wish to make about this patient's condition, then, proceed to sections F and G and sign and date the form.

If you have not checked any of the boxes in section C, please complete section D. See part VI of the instruction sheet for definitions of the terms we use in section D. Proceed to section E if you have any remarks you wish to make about this patient's condition. Then, proceed to sections F and G and sign and date the form.

**D. OTHER MANIFESTATIONS OF HIV INFECTION**

42. a. **REPEATED MANIFESTATIONS OF HIV INFECTION**, including diseases mentioned in section C, items 1-41, but without the specified findings described above, or other diseases, resulting in significant, documented, symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

Please specify:

1. The manifestations your patient has had;
2. The number of episodes occurring in the same 1-year period; and
3. The approximate duration of each episode.

Remember, your patient need not have the same manifestation each time to meet the definition of repeated manifestations; but, all manifestations used to meet the requirement must have occurred in the same 1-year period. (See attached instructions for the definition of repeated manifestations.)

If you need more space, please use section E.

MANIFESTATIONS:	NO. OF EPISODES IN THE SAME 1-YEAR PERIOD:	DURATION OF EACH EPISODE:
EXAMPLE: Diarrhea	3	1 month each

**AND**

b. ANY OF THE FOLLOWING:

- Marked restriction of **ACTIVITIES OF DAILY LIVING**; or
- Marked difficulties in maintaining **SOCIAL FUNCTIONING**; or
- Marked difficulties in completing tasks in a timely manner due to deficiencies in **CONCENTRATION, PERSISTENCE, OR PACE.**

**E. REMARKS:** *(Please use this space if you lack sufficient room in section D or to provide any other comments you wish about your patient.)*

**F. MEDICAL SOURCE'S NAME AND ADDRESS** *(Print or type)*

TELEPHONE NUMBER (Area Code)

DATE

**KNOWING THAT ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW, I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.**

**G. SIGNATURE AND TITLE** (e.g., physician, R.N.) OF PERSON COMPLETING THIS FORM

**FOR OFFICIAL USE ONLY**

**FIELD OFFICE DISPOSITION:**

**DISABILITY DETERMINATION SERVICES DISPOSITION:**