





## 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

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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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## MEDICATIONS

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ADDITIONAL COMMENTS

(Attach additional documentation if needed)

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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 † via email at via fax at

v v v h † " † Ê õ õ Ü õ ? Ê † + õ Ê > " Æ † [¿ ú " À À À + õ ¿ I Ê Æ](#) (562) 985-7183

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