PEDIATRIC EVALUATION AND REPORT GUIDELINES

Provide a typed consultative examination (CE Report) within twelve (12) calendar days of the examination.

Provide the DDDS claimant's name, case number, and date of examination on the first page of the typed report. All subsequent pages shall contain the DDDS claimant's name and case number.

Comply with the detail and format for reporting the results of the consultative examination in accordance with the following consultation examination guidelines (including specific information requested on the Examination Authorization (L9CEVCHR)).

(1) **Identify DDDS Claimant (or Child).**

(a) Include the DDDS claimant's case number
Indicate that the DDDS claimant provided proof of identity by showing an original document proving U.S. citizenship, age and identity (i.e. social security card, U.S. passport, birth certificate, student or school ID, daycare center or school record)

AND

Provide a physical description of the DDDS claimant, to help ensure that the person being examined is the DDDS claimant

*** ***DO NOT PERFORM PELVIC or BREAST EXAMINATIONS UNLESS AUTHORIZED.*** ***

(2) **Chief Complaint.** State the major or chief complaint(s) alleged as the reason for disability. Describe how the impairment(s) affects function and daily activities. Clarify functional loss by providing specific examples of capabilities and activities of daily living.

(3) **Review of Records.** Provide a brief summary or list of background material or medical records received and reviewed prior to the examination. A statement should be made if no medical documents were made available for review by the DDDS.

(4) **History.** Identify the person(s) providing the oral medical history and comment on validity and reliability of the person's reporting.

(a) Past and Present Illness. This section of the examination report should describe and discuss the DDDS claimant's:
i. Prenatal, delivery, and neonatal course
ii. Other significant past illnesses, injuries, operations, hospitalizations, and urgent care encounters with dates of the events and names of facilities where diagnosis and treatment were given (when appropriate)
iii. Onset and duration of the impairment(s)
iv. If episodic, provide dates of episodes, precipitating factors, and the state of health and function of the child between episodes
v. Current treatment. Include medicines and dosages, role of child and caregiver in administration of medications and treatment plan, adjustments in medication regimen.
vi. Special therapy, equipment or devices.
vii. Response to treatment and extent of control of the impairment(s)
viii. Source(s) of medical and/or surgical care. Include hospitals, specialist, or specialty clinics.
ix. Unmet medical or surgical care needs

b. Social History. Include pertinent findings about use of tobacco products, alcohol,

prescription/non-prescription drugs, etc. (as appropriate).

c. Family History. Describe and discuss family composition, health of family members, similar disease/disorder in other members of the family, the primary caretaker(s) and their role in providing for the DDDS claimant's medical and daily activity needs.

(5) **Review of Systems.** Describe and discuss:

(a) Other complaints and symptoms the DDDS claimant has experienced
(b) Pertinent negative findings of the DDDS claimant relevant to the specific impairment(s) being examined and not otherwise described in current medical history

(6) **Growth and Development.** Describe and discuss (as appropriate):

(a) Any growth delay when impairment(s) would be expected to affect growth
(b) Developmental milestones if under age 6
(c) Early infant of preschool intervention services
(d) For children 6 years and older, usual daily activities
(e) Current grade, type of class, limitations of activities or need for special assistance or extra care

(7) **Physical Examination.** Cover every section of physical. Provide specific information and be as descriptive as possible. Include direct quotes by the child or caregiver when appropriate.

(a) Vital signs. Blood pressure; pulse rate; respiratory rate (as appropriate)
(b) Length, height and weight measurements and percentiles (based on most recent CDC growth standards)
(c) Head circumference if under age 3, or if a neurological or mental impairment is involved
(d) Tanner stage (as appropriate)
(e) General Appearance and Physical Observations
    i. Describe the DDDS claimant's general appearance and include obvious vision or hearing problems, facial, skeletal or other abnormalities (as appropriate)
    ii. Description of the interaction with the examiner and ability to understand directions and communicate clearly with content appropriate for age
(f) Specific Findings. The examination should concentrate on the systems affected by the DDDS claimant's illness or impairment. Be as detailed as possible.
    i. Cardiac
        (A) Rate, rhythm and sounds, including murmurs
        (B) Evidence of cyanosis (perioral, peripheral), pallor, or clubbing
        (C) Presence of hepatomegaly or edema
    ii. Pulmonary.
        (A) Chest wall abnormality, labored breathing, audible wheezing, cough
        (B) Abnormal auscultation findings
        (C) Presence of tracheostomy, oxygen need, G-tube, central venous line
    iii. Musculoskeletal
        (A) Gait and station
            a. Ability to ambulate and balance
            b. Need for and ability to use assistive device
        (B) Upper Extremities
            a. Fine and gross motor movements and coordination
            b. Describe quality of movements and presence of extraneous movements
        (C) Limb Deficiency
            a. Description of stump and skin flap integrity
            b. Tenderness

c. Ability to use, and effective use, of any prosthetic device

(D) Joints
a. Joint abnormality
b. Active and passive movement
c. Range of motion

(E) Spine
a. Note any deformities including scoliosis or kyphosis
b. Range of motion

(F) Soft Tissue Injuries/Burns. Describe:
a. Nature and extent
b. Skin sensitivity
c. Effect on joint motion

iv. Neurological

(A) Describe motor function (0 to 5 scale, 5 is normal). Comment on degree of motor function that may be inhibited by spasticity, rigidity, or pain.

(B) Reflex activity and any sensory deficits. Comment on specific distribution of sensory deficit (i.e. The DDDS claimant had diminished pinprick over the left calf). Deep tendon reflexes should be described as to intensity and symmetry.

(8) **Laboratory and Diagnostic Studies.**

(a) Report x-ray findings and/or actual lab values, with the lab's normal range. If the interpretation is provided separately, the report sheet should state the interpreting medical source's name and address and attached to the signed consultative examination report.
(b) Identify the medical source (name and address) providing the formal interpretation of the laboratory tests when the source is other than the individual signing the report
(c) Provide interpretation of laboratory results that takes into account, and correlates with, the history and physical examination findings

(9) **Diagnosis.**

(a) Provide a diagnosis based on clinical, objective evidence
(b) Include a discussion of which findings and observations led to this diagnoses
(c) Do not give diagnoses based solely on the DDDS claimant's subjective complaints

(10) **Prognosis.** Note probable duration and expected results of current treatment.

(11) **Medical Opinion** (remaining functional abilities)**.**

(a) Based on the objective examination findings, provide an opinion of the DDDS claimant's (or child's) ability to do function as compared to other children of the same age who do not have impairments.
(b) This statement must be supported by the objective clinical findings.

(11) **Report Signature.** The report is required to be reviewed and signed by the doctor who performed the consultative examination.

(a) A rubber stamp signature or a signature by another doctor or provider is not acceptable
(b) It is not acceptable to indicate "not proofed" or "dictated, but not read" on the report
(c) The performing doctor's name must be typed at the end of the report despite the report being wet-signed or electronically signed
i. If the report is to be submitted via Social Security's Electronic Records Express secured website, using the "click and sign" feature is an acceptable electronic signature