

SURGERY WORKSHEET

CLIENT NAME		DATE
AGE	CASE NUMBER	
COUNSELOR	DISTRICT OFFICE Springfield South	
CPT CODE*	Y/N	PROCEDURES (DO NOT LEAVE BLANK)
*CPT CODE: Is the CPT code valid for authorizations? Please mark Y or N in the space provided.		

DOES THIS PROCEDURE REQUIRE INPATIENT HOSPITALIZATION? [MUST MARK ONE]	<input type="checkbox"/> YES [#DAYS]	<input type="checkbox"/> NO
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COUNSELOR RATIONALE FOR SURGERY
(REASON FOR REQUESTED PROCEDURE AND HOW IT WOULD IMPACT ON CLIENT'S EMPLOYABILITY)

COUNSELOR SIGNATURE	DATE	SUPERVISOR SIGNATURE	DATE
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BASED UPON THE OBJECTIVE MEDICAL EVIDENCE AND/OR HISTORY:

I CONCUR WITH THE RECOMMENDATIONS FOR MEDICAL INTERVENTION.
(THIS IS NOT A STATEMENT OF ELIGIBILITY. THE COUNSELOR MUST STILL DOCUMENT ELIGIBILITY IN ACCORDANCE WITH CFR 361.31)

I DO NOT CONCUR WITH THE RECOMMENDATIONS FOR MEDICAL INTERVENTION.
