**Medical listing 6.01, 6.02. 6.06**

Category of Impairments, 6.01 Genito urinary system:   
  
6.02, Impairment of Renal Function: Does your client have an impairment of renal function due to any chronic renal disease that has either lasted or is expected to last 12 months (e.g., Hypertensive vascular disease, chronic nephritis, nephrolithiasis, polycystic disease, bilateral Hydronephrosis, etc.) with:

A. Chronic hemodialysis or peritoneal dialysis necessitated by irreversible renal failure;

\_\_\_\_ Yes \_\_\_\_\_No, or

B. Kidney transplant. (Please consider this to be a disability if for 12 months following surgery and thereafter the claimant is still affected by residual impairments);

\_\_\_\_ Yes \_\_\_\_\_No, or

C. Persistent elevation of serum creatine to 4 mg/dL (100 ml.) or greater or reduction of creatine clearance to 20 mL per minute (29 Liters per 24 hours) or less, over at least three months, \_\_\_\_\_Yes \_\_\_\_\_No, with one of the following;

1. Renal osteodystrophy manifested by severe bone pain and abnormalities shown by appropriate medical acceptable imaging (e.g. Osteitis fibrosa, marked osteoporosis, pathologic fractures); \_\_\_\_ Yes \_\_\_\_\_No, or

2. A clinical episode of Pericarditis; \_\_\_\_ Yes \_\_\_\_\_No, or

3. Persistent motor or sensory neuropathy; \_\_\_\_ Yes \_\_\_\_\_No, or

4. Intractable pruritus; \_\_\_\_ Yes \_\_\_\_\_No, or

5. Persistent fluid overload syndrome resulting in diastolic hypertension (110 mm or above) or signs of vascular congestion; \_\_\_\_ Yes \_\_\_\_\_No, or

6. Persistent anorexia with recent weight loss and current weight loss; \_\_\_\_ Yes \_\_\_\_\_No, or

7. Persistent hematocrits of 30% or less? \_\_\_\_ Yes \_\_\_\_\_No  
  
6.06, Nephrotic syndrome with significant anasarca, persistent for at least three months despite prescribed therapy with: A. Serum albumin of 3.0 g/dL (100 mL) or less and Proteinuria of 3.5 g per 24 hrs. or greater; or B. Proteinuria of 10.0 g per 24 hours or greater? \_\_\_\_ Yes \_\_\_\_\_No

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**Physician’s Signature Date**

**Please attach Physician’s Card Below:**