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| Texas Workforce Solutions logo | | | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **End-Stage Renal Disease Evaluation** | | | | | | | | | | | | | | | | | |
| The information requested is necessary to help counselors determine eligibility and/or a plan for rehabilitation services for the person named. | | | | | | | | | | | | | | | | | | | | | | | |
| **Return Information** | | | | | | | | | | | | | | | | | | | | | | | |
| Return Report To (Name): | | | | | | | | | | | | | | | | | | | | Telephone Number:  (   ) | | | |
| Address: | | | | | | | | | City: | | | | | | | | State: | | | | | | ZIP Code: |
| **Patient Information** | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | Date of Birth: | | | | | | Case ID Number: | | | | | | | | Telephone Number:  (   ) | | | |
| Reported Disability: | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for Referral: | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical History** | | | | | | | | | | | | | | | | | | | | | | | |
| Condensed medical history: | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis: | | | | | | | | | | | | | | | | | | | | | | | |
| **Etiology** (enter X to select all that apply)**:** | | | | | | | | | | | | | | | | | | | | | | | |
| Glomerulonephritis | | | | | | Diabetes mellitus | | | | | | | | | | | | | | | | | |
| Interstitial nephritis | | | | | | Polycystic disease | | | | | | | | | | | | | | | | | |
| Nephrosclerosis | | | | | | Lupus erythematosus | | | | | | | | | | | | | | | | | |
| Malignant hypertension | | | | | | Other (specify): | | | | | | | | | | | | | | | | | |
| **Associated abnormality** (enter X to select all that apply)**:** | | | | | | | | | | | | | | | | | | | | | | | |
| Uremia | | | | | | Osteoporosis | | | | | | | | | | | | | | | | | |
| Anemia | | | | | | Peripheral neuropathy | | | | | | | | | | | | | | | | | |
| Hyperparathyroidism | | | | | | Other(s) (list): | | | | | | | | | | | | | | | | | |
| **Physical Exam** | | | | | | | | | | | | | | | | | | | | | | | |
| Height: | | Weight: | | | | | Blood Pressure:       / | | | | | | | Pulse: | | | | | | | | Respiration: | |
| Vision | (Snellen) | | | | | | | | | R: 20/ | | | | | L: 20/ | | | | | | | | |
| (with glasses, if available) | | | | | | | | | R: 20/ | | | | | L: 20/ | | | | | | | | |
| Abnormal findings: | | | | | | | | | | | | | | | | | | | | | | | |
| **Laboratory Data** | | | | | | | | | | | | | | | | | | | | | | | |
| Glomerular Filtration Rate (GFR): | | | | | | | | | | | | | Hemoglobin: | | | | | | | | | | |
| Serum creatinine: | | | | | BUN: | | | | | | | | Hematocrit: | | | | | | | | | | |
| **Present Treatment** | | | | | | | | | | | | | | | | | | | | | | | |
| Hemodialysis | | | CAPD | | | | | Intermittent peritoneal dialysis | | | | | | | | | | | Kidney transplant | | | | |
| Other | | | | | | | | | | | | | | | | | | | | | | | |
| If on hemodialysis, can dialysis schedule be changed to accommodate work or training schedule?     Yes    No | | | | | | | | | | | | | | | | | | | | | | | |
| Indicate type of AV shunt, if present: | | | | | | | | | | | | | | | | | | | | | | | |
| History of problems with shunt? | | | | | | | | | | | | | | | | | | | | | | | |
| **Prescribed Medications** | | | | | | | | | | | | | | | | | | | | | | | |
| Prescribed Medications/Dosage | | | | Indications (Purpose) | | | | | | | | | | | | Possible Side Effects | | | | | | | |
|  | | | |  | | | | | | | | | | | |  | | | | | | | |
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| Treatment side effects and/or symptoms following dialysis: | | | | | | | | | | | | | | | | | | | | | | | |
| **Physical and Functional Limitations** | | | | | | | | | | | | | | | | | | | | | | | |
| Type X to select your opinion of current physical capabilities: | | | | | | | | | | | | | | | | | | | | | | | |
| Walking (level):    Unlimited    1-2 miles    ½-1 mile    1-2 blocks    100 ft. or less | | | | | | | | | | | | | | | | | | | | | | | |
| Lifting (more than 3 times per hour in an 8-hour workday):     60-100 lbs.    40-60 lbs.    25-40 lbs.    10-25 lbs.    10 lbs. or less | | | | | | | | | | | | | | | | | | | | | | | |
| Standing:    6-8 hr /workday    4-6 hr /workday    2-4 hr /workday    0-2 hr /workday | | | | | | | | | | | | | | | | | | | | | | | |
| Other functional limitations (please describe): | | | | | | | | | | | | | | | | | | | | | | | |
| Working conditions. Type X to select any condition to be avoided:     Outdoors    Indoors    High humidity    Dry    Dusty    Marked temperature changes     Other: | | | | | | | | | | | | | | | | | | | | | | | |
| Special considerations and precautions: | | | | | | | | | | | | | | | | | | | | | | | |
| Recommendations and remarks: | | | | | | | | | | | | | | | | | | | | | | | |
| **All information is to be treated as confidential.**  **Examinee has the legal right to see this report when the examinee requests.** | | | | | | | | | | | | | | | | | | | | | | | |
| Type or Print Physician's Name: | | | | | | | | | | | | | | | | | | Telephone Number:  (   ) | | | | | |
| Address: | | | | | | | | | | | City: | | | | | | | State: | | | ZIP Code: | | |
| Examining Physician Signature:  **X** | | | | | | | | | | | | | | | | | | Date of Examination: | | | | | |