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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****General Physical Examination Report**   |
| 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:       |
| Social Security Number:       | Telephone Number: (   )       |
| Reported Disability:      |
| Reason for Referral:      |
| Condensed Medical History |
| Provide a condensed medical history:      |
| Examination |
| Please describe any abnormalities:      |
| Height:      | Weight:       | Pulse:      | Blood Pressure:      |
| Vision (Snellen):Right 20/       Left 20/        | With glasses, if available: Right 20/       Left 20/       |
| **Health Status**   |
| Please enter X to select **Yes No** | **Comments** |
| Diabetes |    |    |       |
| Anemia |    |    |       |
| Headaches |    |    |       |
| Kidney disease |    |    |       |
| Thyroid problems |    |    |       |
| Seizures |    |    |       |
| Alcohol/drug abuse |    |    |       |
| Mobility problems |    |    |       |
| Asthma |    |    |       |
| Physical limitations |    |    |       |
| Heat intolerance |    |    |       |
| Other: |    |    |       |
| **Examination:** Please enter X to select Normal or Abnormal.   |
|  | **Normal** | **Abnormal** | **Comments** |
| Pulse |    |    |       |
| Blood pressure |    |    |       |
| Head-scalp |    |    |       |
| Eyes |    |    |       |
| Ears-nose-throat |    |    |       |
| Dental-mouth |    |    |       |
| Neck |    |    |       |
| Skin |    |    |       |
| Chest-lungs |    |    |       |
| Heart-arteries |    |    |       |
| Abdomen |    |    |       |
| Hernias |    |    |       |
| Bones-joints |    |    |       |
| Muscular |    |    |       |
| Neurological |    |    |       |
| Genitourinary |    |    |       |
| Laboratory |
| Urine: | Dipstick urinalysis for protein, sugar, and hemoglobin is required, or more complete urinalysis with microscopic if examiner feels it is needed.   |
| Results: Enter an X to select: |    Within normal limits |    Abnormal |
| If Abnormal, please explain:       |
| Blood: | Physician may do hemoglobin (or hematocrit) and serology, if indicated.  |
| Results: Enter an X to select: |    Within normal limits |    Abnormal |
|  | If Abnormal, please explain:       |
| X-Ray |
| X-Ray: | With this general examination, chest x-rays (AP & lateral) are authorized when physician indicates need. These x-rays should be obtained if evidence of past or present TB exists, or presence of other active pulmonary disease is found during exam. Other x-ray studies require prior authorization for payment by counselor. Fees paid for these procedures may not exceed the TWC-VR fee schedules.     |
|  | Results: Enter an X to select: |    Within normal limits |    Abnormal |
| If Abnormal, please explain:       |
| Diagnosis and Impressions |
| Diagnosis:      |
| Your Opinion: Can the major disability be removed or substantially improved by medical or surgical treatment? |     Yes    No  |
| If No, please explain:      |
| **Functional Assessment** |
| What can this person do now? Please enter X to select the appropriate checkboxes that are applicable during an 8-hour workday:     |
|  | Continuously 66% or more of the time | Frequently 33-66% of the time | Occasionally Up to 33% of the time | Not at all |
| Sitting |    |    |    |    |
| Standing |    |    |    |    |
| Walking |    |    |    |    |
| Lifting 10 or less lbs. |    |    |    |    |
| Lifting 10-20 lbs. |    |    |    |    |
| Lifting 20-50 lbs. |    |    |    |    |
| Lifting 50-100 lbs. |    |    |    |    |
| Lifting over 100 lbs. |    |    |    |    |
| Bending |    |    |    |    |
| Stooping, kneeling, squatting, & crouching |    |    |    |    |
| Crawling |    |    |    |    |
| Climbing & balancing |    |    |    |    |
| Other functional limitations |    |    |    |    |
| (please describe):       |
| **Working Conditions** |
| Please enter X to select any condition(s) to be avoided: |
|     Outdoors |     Dry |     Marked temperature changes |
|     Indoors |     Dusty |
|     High humidity |     Other:       |
| **Recreational Clearance (Criss Cole Rehabilitation Center)**  |
| Is there any reason this individual should not participate in recreation activities, including physical conditioning?    Yes    No |
| If yes, explain:       |
| Remarks and/or Recommendations |
| Any other remarks or recommendations; for example, other diagnostic examinations:      |
| **All information is treated as confidential.****Examinee has the legal right to see this report when the examinee requests.** |
| Examining Physician's Name (type or print):      | Telephone Number:(   )       |
| Physician’s Address:       | City:       | State:       | ZIP Code:      |
| Examining Physician’s Signature:**X**       | Date of Examination:      |