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| **Texas Workforce Solutions logo** | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Consultant Review** | | |
| **Customer Data** | | | |
| Customer name: | | Case ID: | Counselor name: |
| Counselor questions or comments, if any: | | | |
| **Medical Consultant Recommendations** | | | |
| The recommendations on this form are valid only six months from the date of the physician’s signature. | | | |
| Review type:  Medical  Psychological  Dental | | | |
| Review of data demonstrates impairment exists?  Yes  No  Comments: | | | |
| Diagnostic studies appear adequate?  Yes  No | | | |
| Additional medical, psychiatric, dental, and/or psychological information needed to:  Establish diagnosis  Establish presence of disability  Establish prognosis | | | |
| Specialist examination(s) needed?  Yes  No  If yes, explain: | | | |
| Comments: | | | |
| **Restoration** | | | |
| Physical, mental, or dental restoration services indicated?  Yes  No  If yes, explain: | | | |
| Comments: | | | |
| Physician’s Printed Name: | | | Date: |
| Physician’s Signature:  **X** | | | Date: |