TEXAS WORKFORCE SOLUTIONS

Texas Workforce Commission
Vocational Rehabilitation Services

Pulmonary Evaluation Report

The information requested is necessary to help counselors determine eligibility and/or a plan for rehabilitation services for the person named.

Return Information To

Name:		Telephone number:	
Address:	City:	State:	ZIP code:

Consumer Data

Name:	Birth date:	Social Security number:	Telephone number:

Reported disability:

Reason for referral:

Test Results

Forced expiratory volume (FEV) 0.5 sec:	FEV 1.0 sec.:	FEV 3.0 sec.:
Maximum voluntary ventilation (MVV):	Total vital capacity:	Predicted vital capacity:
_____ L/min.	_____ ml.	_____ ml.

Other objective test results:

Diagnosis

Condition:

Major symptoms:

Duration: years Degree of impairment: ☐ mild ☐ moderate ☐ severe

Disease is: ☐ stable ☐ progressive ☐ improving ☐ recurrent

Treatment now being given:

Is special equipment or oxygen used? ☐ Yes ☐ No	If yes, what:
Is other treatment needed? ☐ Yes ☐ No	If yes, what:

If tuberculosis:	Type of treatment (specify):
Date of onset:	

Date of last positive sputum: smear: culture: X-ray:

Where are follow-up exams obtained?

How long considered inactive?

Prescribed Medications/Dosage	Indications (Purpose)	Possible Side Effects

Functional Ability

What can the patient do now? Select capacities that are applicable during an 8-hour day.

Sitting:	☐ Unlimited	☐ 75% of time	☐ 50-75% of time	☐ 25-50% of time	☐ 10% or less
Walking:	☐ Unlimited	☐ 1-2 miles	☐ 1/2-1 mile	☐ 1-2 blocks	☐ 100 ft. or less
Lifting:	☐ 60-100 lb.	☐ 40-60 lb.	☐ 25-40 lb.	☐ 10-25 lb.	☐ 10 lb. or less
Stairs:	☐ Unlimited	☐ 2 flights	☐ 1 flight	☐ 1-4 steps	☐ none
Bending:	☐ Unlimited	☐ Limited			

Other:

Prognosis

1. For improvement of pulmonary disease:	☐ good	☐ poor	☐ questionable
2. As to longevity and general health:	☐ good	☐ poor	☐ questionable
3. As to work capacity (moderately active job):	☐ improve	☐ decline	☐ remain the same
4. Probably ultimate work capacity:	☐ full-time	☐ part-time	☐ unknown

Enter the number of hours of work per day recommended: _____

Enter the number of weeks or months this limitation is expected to last: _____

5. Types of activity to be avoided:

6. Working conditions to be avoided:

7. Enter the number of weeks or months that medical check-ups are needed:

Recommendations or 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 and address:		Telephone number:	
Address:	City:	State:	ZIP Code:
Physician's Signature: **X**		Examination date:	