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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 |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| 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:      |