TEXAS WORKFORCE SOLUTIONS

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:	Social Security Number:	Telephone Number:

Reported Disability:

Reason for Referral:

Medical History

Condensed medical history:

Diagnosis:

Etiology (select all that apply):

- ☐ Glomerulonephritis
- ☐ Interstitial nephritis
- ☐ Nephrosclerosis
- ☐ Malignant hypertension
- ☐ Diabetes mellitus
- ☐ Polycystic disease
- ☐ Lupus erythematosus
- ☐ Other (specify):

Associated abnormality (select all that apply):

- ☐ Uremia
- ☐ Anemia
- ☐ Hyperparathyroidism
- ☐ Osteoporosis
- ☐ Peripheral neuropathy
- ☐ 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

Select your opinion of current physical capabilities:

Walking (level): ☐ Unlimited ☐ 1-2 miles ☐ 1/2-1 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. 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:	