



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:	