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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****Cardiac Evaluation Report**   |
| The information requested is necessary to help counselors determine eligibility and/or a plan for rehabilitation services for the person named.   |
| **Return Report To** |
| Name:      | Telephone number:(   )       |
| Address:      | City:      | State:      | ZIP code:      |
| **Customer Data** |
| Name:      | Birth date:      | Case ID number:      | Telephone number:(   )       |
| **Reported disability**:       |
| **Reason for referral**:       |
| **Medical History** |
| Condensed medical history regarding onset, duration, severity:       |
| **Symptoms** (enter x to select all that apply) | **Yes** | **No** | **If yes, frequency** | **Comments** |
| Angina |    |    |       |       |
| Palpitations |    |    |       |       |
| Orthopnea |    |    |       |       |
| Exertional Dyspnea |    |    |       |       |
| Fatigue |    |    |       |       |
| Peripheral edema |    |    |       |       |
| Joint and muscle pain |    |    |       |       |
| Depression |    |    |       |       |
| Anxiety |    |    |       |       |
| Other |    |    |       |       |
| Other pertinent physical findings:       |
| **Stress Test** |
| Date:       | Resting BP:       |
| Results:       |
| **Diagnosis and Explanatory Information** |
| Diagnosis and explanatory information:       |
| **Physical or Functional Limitations at This Time** |
| New York Heart Association classification:       | METs level:       |
| Enter X to select your opinion regarding the patient’s physical capacities:  |
| Walking (level):    Unlimited    1-2 miles    ½ to 1 mile    1-2 blocks    100 ft. or less |
| Lifting (more than 3 times/hour in an 8-hour workday):   60-100 lb.    40-60 lb.    25-40 lb.    10-25 lb.    10 lb. or less |
| Standing:    6-8 hr./workday.    4-6 hr./workday    2-4 hr./workday   0-2 hr./workday. |
| Other physical or functional limitations (e.g., climbing ladders, reaching overhead, temperature changes)?       |
| **Prescribed Medications/Dosage** | **Indications (Purpose)** | **Possible Side Effects** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **Other Risk Factors Present** |
| Smoking?    Yes    NoIf yes, how much?       How long?       | Diabetes?    Yes    NoIf yes, controlled?    Yes    No |
| Hypertension?    Yes    NoIf yes, controlled?    Yes    No | Lack of exercise?    Yes    No |
| Diet?    Yes    No |
| Elevated triglycerides or cholesterol?    Yes    NoValue:       | Stress?    Yes    No |
| Weight?    Yes    NoIf Yes, pounds:      Amount overweight:       | Other?    Yes    NoIf Yes, specify:       |
| **Recommendations** |
| Treatment recommended?    Yes    NoIf “Yes,” what type of treatment?      |
| Comprehensive cardiac rehabilitation (where available)?    Yes    NoComments:      |
| Other recommendations:       |
| **Prognosis** |
| If recommendations are followed, how much improvement can be expected in functional capacity?      |
| 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’s Signature:**X**       | Examination date:      |