TEXAS WORKFORCE SOLUTIONS

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:

Consumer Data

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

Reported disability:

Reason for referral:

Medical History

Condensed medical history regarding onset, duration, severity:

Symptoms (select all that apply)	**Yes**	**No**	**If yes, frequency**	**Comments**
Angina	☐	☐		
Palpitations	☐	☐		
Orthopnea	☐	☐		
Extertional 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:

Select your opinion regarding the patient's physical capacities:

Walking (level): ☐ Unlimited ☐ 1-2 miles ☐ 1/2 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 ☐ No		Diabetes? ☐ Yes ☐ No
If yes, how much?	How long?	If yes, controlled? ☐ Yes ☐ No
Hypertension? ☐ Yes ☐ No		Lack of exercise? ☐ Yes ☐ No
If yes, controlled? ☐ Yes ☐ No		Diet? ☐ Yes ☐ No
Elevated triglycerides or cholesterol? ☐ Yes ☐ No		Stress? ☐ Yes ☐ No
Value:		

Weight? ☐ Yes ☐ No If yes, pounds: Amount overweight:	Other? ☐ Yes ☐ No If yes, specify:

Recommendations

Treatment recommended? ☐ Yes ☐ No If "Yes," what type of treatment?

Comprehensive cardiac rehabilitation (where available)? ☐ Yes ☐ No Comments:

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:	