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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Texas Workforce Solutions logo | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Work Restriction Checklist** | | | | | | | | | | | | | |
| The information requested is necessary to help counselors determine eligibility 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: | | | | | | Telephone number:  (   ) | | | |
| **Diagnosis** | | | | | | | | | | | | | | | | | |
| Diagnosis of patient: | | | | | | | | | | | | | | | | | |
| Attach copies of prior medical records. | | | | | | | | | | | | | | | | | |
| **Medications** | | | | | | | | | | | | | | | | | |
| **Prescribed Medications and Dosage** | | | | | **Indications (Purpose)** | | | | | | | **Possible Side Effects** | | | | | |
|  | | | | |  | | | | | | |  | | | | | |
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|  | | | | |  | | | | | | |  | | | | | |
| Does this patient have a medical release for employment? (enter X to select) | | | | | | | | | | | | | | | | | |
| Yes, no restrictions | | | Yes, with restrictions listed on form | | | | | | | No  (anticipated date of release): | | | | | | | |
| **Current Restrictions** | | | | | | | | | | | | | | | | | |
| What can the customer do now? Enter X to select capacities applicable during an 8-hour workday. | | | | | | | | | | | | | | | | | |
|  | **Continuously**  67% or more of the time | | | | | | | **Frequently**  34–66% of the time | | | **Occasionally**  Up to 33% of the time | | | | | | **Not at all** |
| **Sitting** |  | | | | | | |  | | |  | | | | | |  |
| **Standing** |  | | | | | | |  | | |  | | | | | |  |
| **Walking** |  | | | | | | |  | | |  | | | | | |  |
| **Lifting** | | | | | | | | | | | | | | | | | |
| 10 lb. or less |  | | | | | | |  | | |  | | | | | |  |
| Up to 20 lb. |  | | | | | | |  | | |  | | | | | |  |
| Up to 50 lb. |  | | | | | | |  | | |  | | | | | |  |
| Up to 100 lb. |  | | | | | | |  | | |  | | | | | |  |
| Over 100 lb. |  | | | | | | |  | | |  | | | | | |  |
|  | **Continuously** | | | | | | | **Frequently** | | | **Occasionally** | | | | | | **Not at all** |
|  | 67% or more of the time | | | | | | | 34–66% of the time | | | Up to 33% of the time | | | | | |  |
| **Bending** |  | | | | | | |  | | |  | | | | | |  |
| **Squatting** |  | | | | | | |  | | |  | | | | | |  |
| **Kneeling** |  | | | | | | |  | | |  | | | | | |  |
| **Twisting** |  | | | | | | |  | | |  | | | | | |  |
| **Reaching** | | | | | | | | | | | | | | | | | |
| Overhead |  | | | | | | |  | | |  | | | | | |  |
| Shoulder level |  | | | | | | |  | | |  | | | | | |  |
| Below waist |  | | | | | | |  | | |  | | | | | |  |
| **Hand function** | | | | | | | | | | | | | | | | | |
| **Simple grasping**  **Left:**    Yes    No **Right:**    Yes    No | | | | | | | | | **Pushing or pulling**  **Left:**    Yes    No **Right:**    Yes    No | | | | | | | | |
| **Fine work**  **Left:**    Yes    No **Right:**    Yes    No | | | | | | | | | **Low-speed assembly**  **Left:**    Yes    No **Right:**    Yes    No | | | | | | | | |
| **High-speed assembly**  **Left:**    Yes    No **Right:**    Yes    No | | | | | | | | | **Unlimited**  **Left:**    Yes    No **Right:**    Yes    No | | | | | | | | |
| **Environmental restrictions:**     Dust    Heat    Cold    Damp or wet    Fumes    Height | | | | | | | | | | | | | | | | | |
| Describe other functional limitations: | | | | | | | | | | | | | | | | | |
| Can this patient engage in training within the functional limitation you have indicated?     Yes    No | | | | | | | | | | | | | | | | | |
| In one day, this patient may work:    4 hr.    4–6 hr.    6–8 hr.    8–10 hr.    10+ hr. | | | | | | | | | | | | | | | | | |
| **Signature** | | | | | | | | | | | | | | | | | |
| All information must be treated as confidential. The examinee has the legal right to see this report when the examinee requests it. | | | | | | | | | | | | | | | | | |
| Type or print the name of the examining physician, physician assistant, or advanced practice nurse: | | | | | | | | | | | | | | | | | |
| Street address: | | | | | | City: | | | | | | | | | State: | ZIP code: | |
| Examiner’s signature:  **X** | | | | | | Telephone number:  (   ) | | | | | | | | | Date: | | |