



**Texas Workforce Commission**  
**Vocational Rehabilitation Services**  
**Eye Surgery and Treatment**  
**Recommendations**

Note to physician: The overall goal of Vocational Rehabilitation (VR) is to improve the customer's ability to gain or maintain employment. All information requested is necessary to help VR counselors plan for VR services for the individual named. List the recommendation for a single date of service. If the recommendation is for bilateral or staged surgeries on multiple dates of service, list the time range and number of separate procedures expected. The recommendation(s) on this form is (are) only valid for six months from the date of the physician's signature.

**Patient Information**

Customer's name:	Date of birth:	Case ID:	Telephone number: ( )
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Reported visual disability:

Reason for eye surgery or treatment referral:

**Return Information**

Return report to:	Telephone number: ( )
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Address:	Fax number: ( )
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City:	State:	ZIP code
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**Completed by Physician**

The recommendation(s) on this form is (are) only valid for six months from the date of the physician's signature.

Diagnosis with ICD 10 codes:

Type of surgery recommended (**specify right, left, or bilateral**).

CPT codes:

Where will the surgery be provided?

Physician's Office    Hospital    Surgical Center    Other Facility

If a bilateral or staged surgery is recommended, provide the projected time frame for each eye:

Number of separate procedures expected:

Type of treatment(s) recommended ( <b>specify right, left, or bilateral</b> ).			
CPT codes:			
If injections are an anticipated treatment, provide a projected time frame, provide the quantity of injections, indicate whether laser is recommended (per eye) for patient stability, or describe the projected plan for the customer:			
Where will the treatment be provided? Physician's Office      Hospital      Surgical Center      Other Facility If a bilateral or staged treatment is recommended, provide the projected time frame for each eye:			
What type of anesthesia will be used? General      Local Subconjunctival Lidocaine or Retrobulbar Injection      Topical anesthetic Who will provide the anesthesia to the patient?      Anesthesiologist or CNRA      Surgeon			
Is there currently an immediate danger of vision loss?      Yes      No			
If a corneal transplant is recommended, what is the projected cost of the tissue?			
Can the procedure be performed as day surgery?      Yes      No			
Complete name of the hospital or facility to be used:			
Number of office visits required: Preoperative: Postoperative:		Preoperative diagnostic tests, injections, or other recommendations (include codes):	
<b>Anticipated Ancillary Services</b>			
Name of anesthesiologist or group:			
Name of co-surgeon (if required):		Name of laboratory and/or pathology group (if required):	
<b>Physician Information and Signature</b>			
All information must be treated as confidential. Examinee has the legal right to see this report on request.			
Type or print the physician and group/clinic name:			Date of examination:
Telephone number: (    )		Fax number: (    )	
Physician's address:		City:	State:      ZIP code:
Examining physician's signature: <b>X</b>			Date: