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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****Surgery and Treatment Recommendations**   |
| The information requested is necessary to help counselors plan for rehabilitation services for the person 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.   |
| **Patient Information** |
| Name:      | Date of birth:      | Case ID:      | Telephone number:(   )       |
| Reported Disability:      |
| Reason for referral:      |
| **Return Information** |
| Return Report to:       | Telephone number:(   )       |
| Address:      | FAX number:(   )       |
| City:       | State:       | ZIP code      |
| **Completed by Physician**  |
| The recommendation(s) on this form is only valid 6 months from the date of physician’s signature.   |
| Diagnosis with ICD 10 codes:      |
| Type of treatment procedure(s) recommended **(right, left, bilateral, or spinal levels). Include CPT codes and your usual fees**:     Type of implants recommended:      |
| **Note**: TWC does not provide additional payment for use of a robotic surgical system. Advance approval is required for codes ending in 99 or T.  |
| Can procedure be performed as day surgery? [ ]  Yes [ ]  No  |
| Complete name of hospital or facility to be used:      |
| Number of hospital days:      | Will blood be needed? [ ]  Yes [ ]  NoEstimated pints needed:       |
| Number of office visits required:Pre-operative:      Post-operative:       | Pre-operative diagnostic tests, injections or vaccinations required (include codes):      |
| **Anticipated Ancillary Services** |
| Name of anesthesiologist or group:      | Name of radiology group (if required):      |
| Name of assistant surgeon (if required):      | Name of laboratory and/or pathology group (if required):       |
| Surgical monitoring required? [ ]  Yes [ ]  NoName or Group:       | Will hospitalists be used? [ ]  Yes [ ]  NoName or Group       |
| **Post-Surgical Rehabilitation** |
| Type of rehabilitation required: [ ]  Inpatient [ ]  Outpatient [ ]  Home Health |
| Therapy type: [ ]  PT [ ]  OT [ ]  ST Other:       |
| Length of therapy time:       |
| **Durable Medical Equipment Needs (DMEs)**  |
| DME: | Duration of Use: |
|       |       |
|       |       |
| **Employment**  |
| Will the recommended treatment or surgery improve the patient’s functional abilities enough that he or she can work after completion of recommended treatment? [ ]  Yes [ ]  No |
| If yes, indicate what level of work this patient is expected to be able to perform after the completion of recommended treatment: [ ]  sedentary, [ ]  light, [ ]  medium, or [ ]  heavy |
| Estimated time to return to work after completion of recommended treatment:      |
| **Physician Information and Signature** |
| All information must be treated as confidential.Examinee has the legal right to see this report when the examinee requests.   0  |
| 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:**X**       | Date:      |