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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** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| Does this patient have a medical release for employment? (enter X to select) |
|    Yes, no restrictions |  Yes, with restrictions listedon 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:      |