|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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  No  Estimated 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  No  Name or Group: | | | | | Will hospitalists be used?  Yes  No  Name 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: | | | |