TEXAS WORKFORCE SOLUTIONS

Texas Workforce Commission
Vocational Rehabilitation Services

Cancer Disability Medical Report

The information requested is necessary to help counselors determine eligibility and/or a plan for rehabilitation services for the person named.

Return Information

Return report to (name):			Telephone number:
Address:	City:	State:	ZIP code:

Consumer Data

Consumer's name:	Birth date:	Social Security number:	Telephone number:

Reported Disability:

Reason for Referral:

Diagnosis

Diagnosis:	Primary site:

Is there known metastasis? ☐ Yes ☐ No

Probable metastasis? ☐ Yes ☐ No

Treatment received (list surgical procedures, other modalities used):

Medications

Prescribed Medications/Dosage	Indications (Purpose)	Possible side effects

Is additional treatment anticipated? ☐ Yes ☐ No

List type and estimated length of time:

Current physical findings (include noncancerous conditions):

Is patient motivated toward hopeful functional recovery? ☐ Yes ☐ No

Plans for medical follow-up:

Need for prostheses, devices, appliances (e.g., artificial limb, breast prosthesis, etc.):

Prognosis

General (based on past experience with this diagnostic group):

Specific (as related to this particular patient):

Employment Potential

Return to former occupation? ☐ Yes ☐ No

Limitations (number of hours, environment, etc):

Functional and Disease Classification

Functional Classification (select one):

- ☐ Able to carry on normal daily activities and/or to return to previous environment.
- ☐ Able to carry on normal daily activities and/or to should return to full-time employment within the limits of disability.
- ☐ Able to carry on normal daily activities and/or to should return to part-time employment within the limits of disability.
- ☐ Able to work under protected conditions and/or is able to live at home and care for personal needs.
- ☐ Unable to work and/or requires considerable assistance and medical care.
- ☐ Unable to care for self and requires the equivalent of institutional or hospital care.
- ☐ Advanced, rapidly progressing disease.

Extent of Disease Classification (select one):

- ☐ No evidence of residual, recurrent, or metastatic disease.
- ☐ Evidence of residual or recurrent disease.
- ☐ Evidence of distant or generalized metastases.

Does patient know he or she has cancer?	☐ Yes ☐ No

Extent of involvement:

Remarks:

All information is to be treated as confidential.
Examinee has the legal right to see this report when the examinee requests.

Type or print physician's name:	Telephone number:

Address:	City:	State:	ZIP Code:

Examining physician's signature:	Date of examination: