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| Texas Workforce Solutions Logo | | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Pulmonary Evaluation Report** | | | | | | | | | | | | | | |
| The information requested is necessary to help counselors determine eligibility and/or a plan for rehabilitation services for the person named. | | | | | | | | | | | | | | | | | | | |
| **Return Information To** | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | Telephone number:  (   ) | | | | | |
| Address: | | | | | | | | | City: | | | | | State: | | | | | ZIP code: |
| **Customer Data** | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | Birth date: | | | | Case ID number: | | | | | | Telephone number:  (   ) | | | |
| **Reported disability**: | | | | | | | | | | | | | | | | | | | |
| **Reason for referral**: | | | | | | | | | | | | | | | | | | | |
| **Test Results** | | | | | | | | | | | | | | | | | | | |
| Forced expiratory volume (FEV) 0.5 sec.: | | | | | | | | | FEV 1.0 sec.: | | | | FEV 3.0 sec.: | | | | | | |
| Maximum voluntary ventilation (MVV):       L/min. | | | | | | | | | Total vital capacity:        ml. | | | | Predicted vital capacity:        ml. | | | | | | |
| Other objective test results: | | | | | | | | | | | | | | | | | | | |
| **Diagnosis** | | | | | | | | | | | | | | | | | | | |
| Condition: | | | | | | | | | | | | | | | | | | | |
| Major symptoms: | | | | | | | | | | | | | | | | | | | |
| Duration:       years | | Degree of impairment (type x to select):    mild    moderate    severe | | | | | | | | | | | | | | | | | |
| Disease is:    stable    progressive    improving    recurrent | | | | | | | | | | | | | | | | | | | |
| Treatment now being given: | | | | | | | | | | | | | | | | | | | |
| Is special equipment or oxygen used?     Yes    No | | | | | | | If yes, what? | | | | | | | | | | | | |
| Is other treatment needed?     Yes    No | | | | | | | If yes, what? | | | | | | | | | | | | |
| **If tuberculosis:**  Date of onset: | | | | | | | Type of treatment (specify): | | | | | | | | | | | | |
| Dates of last positive sputum:       smear:       culture:       x-ray: | | | | | | | | | | | | | | | | | | | |
| Where are follow-up exams obtained? | | | | | | | | | | | | | | | | | | | |
| How long considered inactive? | | | | | | | | | | | | | | | | | | | |
| **Prescribed Medications/Dosage** | | | | **Indications (Purpose)** | | | | | | | | | **Possible Side Effects** | | | | | | |
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| **Functional Ability** | | | | | | | | | | | | | | | | | | | |
| What can the patient do now? Enter X to select capacities that are applicable during an 8-hour day. | | | | | | | | | | | | | | | | | | | |
| Sitting: | | Unlimited | | 75% of time | | | | | 50-75% of time | | | | 25-50% of time | | | | | | 10% or less | |
| Walking: | | Unlimited | | 1-2 miles | | | | | ½-1 mile | | | | 1-2 blocks | | | | | | 100 ft. or less | |
| Lifting: | | 60-100 lb. | | 40-60 lb. | | | | | 25-40 lb. | | | | 10-25 lb. | | | | | | 10 lb. or less | |
| Stairs: | | Unlimited | | 2 flights | | | | | 1 flight | | | | 1-4 steps | | | | | | none | |
| Bending: | | Unlimited | | Limited | | | | |  | | | |  | | | | | |  | |
| Other: | | | | | | | | | | | | | | | | | | | |
| **Prognosis** | | | | | | | | | | | | | | | | | | | |
| 1. For improvement of pulmonary disease: | | | | | | | | | | good    poor    questionable | | | | | | | | | |
| 2. As to longevity and general health: | | | | | | | | | | good    poor    questionable | | | | | | | | | |
| 3. As to work capacity (moderately active job): | | | | | | | | | | improve    decline    remain the same | | | | | | | | | |
| 4. Probable ultimate work capacity: | | | | | | | | | | full-time    part-time    unknown | | | | | | | | | |
| Enter the number of hours of work per day recommended: | | | | | | | | | | | | | | | | | | | |
| Enter the number of weeks or months this limitation is expected to last: | | | | | | | | | | | | | | | | | | | |
| 5. Types of activity to be avoided: | | | | | | | | | | | | | | | | | | | |
| 6. Working conditions to be avoided: | | | | | | | | | | | | | | | | | | | |
| 7. Enter the number of weeks or months that medical check-ups are needed: | | | | | | | | | | | | | | | | | | | |
| **Recommendations or 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 and address: | | | | | | | | | | | | | | | Telephone number:  (   ) | | | | |
| Address: | | | | | | | | | | | City: | | | | State: | | ZIP Code: | | |
| Physician’s Signature:  **X** | | | | | | | | | | | | | | | Examination date: | | | | |