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| Texas Workforce Solutions logo | | | | **Texas Workforce Commission**  **Vocational Rehabilitation Services**  **Cardiac Evaluation Report** | | | | | | | | | | | | | | |
| The information requested is necessary to help counselors determine eligibility and/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 number: | | | | | Telephone number:  (   ) | | |
| **Reported disability**: | | | | | | | | | | | | | | | | | | |
| **Reason for referral**: | | | | | | | | | | | | | | | | | | |
| **Medical History** | | | | | | | | | | | | | | | | | | |
| Condensed medical history regarding onset, duration, severity: | | | | | | | | | | | | | | | | | | |
| **Symptoms** (enter x to select all that apply) | | **Yes** | **No** | | | | **If yes, frequency** | | | | | | **Comments** | | | | | |
| Angina | |  |  | | | |  | | | | | |  | | | | | |
| Palpitations | |  |  | | | |  | | | | | |  | | | | | |
| Orthopnea | |  |  | | | |  | | | | | |  | | | | | |
| Exertional Dyspnea | |  |  | | | |  | | | | | |  | | | | | |
| Fatigue | |  |  | | | |  | | | | | |  | | | | | |
| Peripheral edema | |  |  | | | |  | | | | | |  | | | | | |
| Joint and muscle pain | |  |  | | | |  | | | | | |  | | | | | |
| Depression | |  |  | | | |  | | | | | |  | | | | | |
| Anxiety | |  |  | | | |  | | | | | |  | | | | | |
| Other | |  |  | | | |  | | | | | |  | | | | | |
| Other pertinent physical findings: | | | | | | | | | | | | | | | | | | |
| **Stress Test** | | | | | | | | | | | | | | | | | | |
| Date: | Resting BP: | | | | | | | | | | | | | | | | | |
| Results: | | | | | | | | | | | | | | | | | | |
| **Diagnosis and Explanatory Information** | | | | | | | | | | | | | | | | | | |
| Diagnosis and explanatory information: | | | | | | | | | | | | | | | | | | |
| **Physical or Functional Limitations at This Time** | | | | | | | | | | | | | | | | | | |
| New York Heart Association classification: | | | | | | | | | | METs level: | | | | | | | | |
| Enter X to select your opinion regarding the patient’s physical capacities: | | | | | | | | | | | | | | | | | | |
| Walking (level):    Unlimited    1-2 miles    ½ to 1 mile    1-2 blocks    100 ft. or less | | | | | | | | | | | | | | | | | | |
| Lifting (more than 3 times/hour in an 8-hour workday):     60-100 lb.    40-60 lb.    25-40 lb.    10-25 lb.    10 lb. or less | | | | | | | | | | | | | | | | | | |
| Standing:    6-8 hr./workday.    4-6 hr./workday    2-4 hr./workday     0-2 hr./workday. | | | | | | | | | | | | | | | | | | |
| Other physical or functional limitations (e.g., climbing ladders, reaching overhead, temperature changes)? | | | | | | | | | | | | | | | | | | |
| **Prescribed Medications/Dosage** | | | | | | **Indications (Purpose)** | | | | | | | | **Possible Side Effects** | | | | |
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| **Other Risk Factors Present** | | | | | | | | | | | | | | | | | | |
| Smoking?    Yes    No  If yes, how much?       How long? | | | | | | | | | | | | Diabetes?    Yes    No  If yes, controlled?    Yes    No | | | | | | |
| Hypertension?    Yes    No  If yes, controlled?    Yes    No | | | | | | | | | | | | Lack of exercise?    Yes    No | | | | | | |
| Diet?    Yes    No | | | | | | |
| Elevated triglycerides or cholesterol?    Yes    No  Value: | | | | | | | | | | | | Stress?    Yes    No | | | | | | |
| Weight?    Yes    No  If Yes, pounds:  Amount overweight: | | | | | | | | | | | | Other?    Yes    No  If Yes, specify: | | | | | | |
| **Recommendations** | | | | | | | | | | | | | | | | | | |
| Treatment recommended?    Yes    No  If “Yes,” what type of treatment? | | | | | | | | | | | | | | | | | | |
| Comprehensive cardiac rehabilitation (where available)?    Yes    No  Comments: | | | | | | | | | | | | | | | | | | |
| Other recommendations: | | | | | | | | | | | | | | | | | | |
| **Prognosis** | | | | | | | | | | | | | | | | | | |
| If recommendations are followed, how much improvement can be expected in functional capacity? | | | | | | | | | | | | | | | | | | |
| 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:  **X** | | | | | | | | | | | | | | | Examination date: | | | |