TEXAS WORKFORCE SOLUTIONS

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

Patient name:	Telephone number:
Date of birth:	Case ID:
Reported disability:	
Reason for referral:	

Return Information

Return this report to:	
Address:	
Telephone number:	FAX number:

Completed by Physician

The recommendation(s) on this form is valid only 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 pre-operative office visits required:
Number of post-operative office visits required:
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 therapy type:
Length of therapy time:

Durable Medical Equipment Needs (DMEs)	
DME:	Duration of Use:
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 ☐ 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.

Physician and group/clinic name:

Date of examination:

Telephone number:	FAX number:

Physician's address:

Examining physician's signature: