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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****Cancer/Diabetes 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:      |
| **Customer Data** |
| Customer’s name:       | Birth date:      | Case ID number:      | Telephone number:(   )        |
| **Reported Disability(ies):**      |
|  **Complications/Comorbidities:**[ ] Hypertension [ ] Dyslipidemia [ ] Stroke [ ] Neuropathy [ ] Peripheral Vascular Disease [ ] Kidney disease [ ] Retinopathy [ ] Congenital heart defects or Coronary heart disease depending [ ] Non-healing wound [ ] Pregnancy [ ] Obesity [ ] Mental/affective disorder[ ] Other:       |
| **Diagnosis** |
|  Diagnoses (Please include ICD 10 codes):      | Primary site:      |
| If relevant – does patient know he or she has cancer? (enter X to select)    Yes    No |
| Is there known metastasis? (enter X to select)   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? (enter X to select)    Yes    NoList type and estimated length of time:        |
| Current physical findings (include noncancerous conditions):      |
| Is patient motivated toward hopeful functional recovery? (enter X to select)    Yes    No |
| Is patient compliant with recommended treatment regimen? (enter X to select)    Yes    No |
| Plans for medical follow-up:      |
| Need for prostheses, devices, appliances (e.g., artificial limb, blood glucose monitor, continuous glucose monitor, insulin pump, etc.):      |
| **Current Lab Tests** |
| [ ] The most current lab results are attached. Individualized targets noted below. |
| Please complete the following for any available results not on a current lab sheet.  The American Diabetes Association Standards of Care recommends individualization of targets. Please document any deviations for the above customer from these target goals considering their medications and disabilities. Pre-prandial blood sugar: 80-130 mg/dL; Postprandial blood sugar: <180 mg/dL; Target Range: 70-180 mg/dL; Hemoglobin A1c: <7% (8% for multiple coexisting chronic illness or 2+ instrumental ADL impairments); GFR >60 mg/g; HDL: >35 mg/dL; Triglyceride level <150 mg/dL.          |
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| **Test** | **Result** | **Date Test Performed** | **Individualized Target** |
| Pre-prandial blood sugar |       |       |       |
| Postprandial blood sugar |       |       |       |
| Target Range (CGM) |       |       |       |
| Hemoglobin A1c |       |       |       |
| Glomerular Filtration Rate |       |       |       |
| High Density Lipoprotein |       |       |       |
| Triglycerides |       |       |       |

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| **Prognosis** |
| General (based on past experience with this diagnostic group):      |
| Specific (as related to this particular patient):      |
| **Employment Potential** |
| Return to former occupation? (enter X to select)    Yes    No |
| Limitations (number of hours, environment, etc.):       |
| **Functional and Disease Classification**  |
| **Functional Classification** (Enter X to 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 should return to full-time employment within the limits of disability.    Able to carry on normal daily activities and/or 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** (Enter X to select one): |
|    | No evidence of residual, recurrent, or metastatic disease. |
|    | Evidence of residual or recurrent disease. |
|    | Evidence of distant or generalized metastases. |
| 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:**X**       | Date of examination:      |