

CABINET FOR WORKFORCE DEVELOPMENT  
DEPARTMENT OF VOCATIONAL REHABILITATION  
**DIAGNOSTIC GENERAL MEDICAL REPORT**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Physician, if any: \_\_\_\_\_

Pertinent History Including Hospitalizations: \_\_\_\_\_

Under Medical Care ☐ Yes ☐ No Current Treatment: \_\_\_\_\_

INDIVIDUAL'S STATEMENT OF DISABILITY:          	SPECIFIC QUESTIONS TO PHYSICIAN:          
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**THIS DIAGNOSTIC EXAM DOES NOT AUTHORIZE TREATMENT!!**

PHYSICIAN'S CLINICAL EVALUATION

*The following information will be used in determining eligibility for vocational rehabilitation services and provide appropriate services if applicant is eligible.*

HEIGHT	WEIGHT	BLOOD PRESSURE	PULSE	NOTES: (Describe every abnormality in detail)
Normal	Check each item in appropriate column			Abnormal
	EYES, EARS, NOSE, THROAT			
	CARDIOVASCULAR			
	NERVOUS SYSTEM			
	RESPIRATORY SYSTEM			
	ABDOMINAL AND GASTROINTESTINAL			
	GENITO-URINARY			
	ENDOCRINE (Include thyroid & breasts)			
	MUSCULOSKELETAL (Include spine, joints, amputations, hernias)			
	OTHER			

Pertinent Lab/X-ray results (if authorized)          	Diagnoses/Etiology          
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<b>COMMUNICATION:</b> VERBAL:      Restricted   • Yes • No HEARING:     No Significant Loss   • Moderate Loss       • Severe Loss           • SIGHT:        No Significant Loss   • Moderate Loss       • Severe Loss           •	<b>ESTIMATED GENERAL PHYSICAL FUNCTION:</b> 1. CAN STAND DAILY, WITH BREAK EVERY 2 HOURS, FOR: • 8 Hours                   • 2 Hours • 6 Hours                   • Not At All • 4 Hours
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Please continue on next page

<p>2. CAN SIT DAILY, WITH BREAK EVERY 2 HOURS, FOR:</p> <ul style="list-style-type: none"> <li>• 8 Hours                      • 2 Hours</li> <li>• 6 Hours                      • Not At All</li> <li>• 4 Hours</li> </ul> <p>3. CAN STAND AND SIT INTERMITTENTLY, WITH BREAK, FOR (Specify hours) _____</p> <p>4. CAN WALK DAILY:</p> <ul style="list-style-type: none"> <li>• Less than 100 yards</li> <li>• About 250 yards (1 city block)</li> <li>• One quarter mile (440 yards)</li> <li>• No restrictions</li> </ul> <p>5. LIFTING: THE MOST REASONABLE LIFTING EXPECTATION FOR THIS INDIVIDUAL IS:</p> <ul style="list-style-type: none"> <li>• 100 lbs. occasionally to 50 lbs. frequently</li> <li>• 50 lbs. occasionally to 25 lbs. frequently</li> <li>• 20 lbs. occasionally to 10 lbs. frequently</li> <li>• 10 lbs. maximum</li> <li>• No Limitations on Individual</li> </ul> <p>6. CLIMBING-BALANCING:    Restricted    • Yes    • No Can climb one flight of stairs without pause    • Yes    • No</p>	<p>7. STOOPING-ENDING:</p> <table style="width: 100%;"> <tr> <td style="width: 60%;">Restricted Bending</td> <td style="width: 40%;">• Yes    • No</td> </tr> <tr> <td>Restricted Stooping</td> <td>• Yes    • No</td> </tr> </table> <p>8. REACHING-HANDLING:</p> <table style="width: 100%;"> <tr> <td style="width: 60%;">Restricted above shoulders</td> <td style="width: 40%;">• Yes    • No</td> </tr> <tr> <td>Restricted below shoulders</td> <td>• Yes    • No</td> </tr> </table> <p>9. USE OF HANDS RESTRICTED:</p> <table style="width: 100%;"> <tr> <td rowspan="2" style="width: 40%;">Simple Grasping</td> <td style="width: 10%;">Right</td> <td style="width: 10%;">• Yes</td> <td style="width: 10%;">• No</td> </tr> <tr> <td>Left</td> <td>• Yes</td> <td>• No</td> </tr> <tr> <td rowspan="2">Pushing &amp; Pulling</td> <td>Right</td> <td>• Yes</td> <td>• No</td> </tr> <tr> <td>Left</td> <td>• Yes</td> <td>• No</td> </tr> <tr> <td rowspan="2">Fine Manipulation</td> <td>Right</td> <td>• Yes</td> <td>• No</td> </tr> <tr> <td>Left</td> <td>• Yes</td> <td>• No</td> </tr> </table> <p>10. USE OF FEET RESTRICTED FOR TREADING (as in operating foot controls)</p> <table style="width: 100%;"> <tr> <td style="width: 60%;"></td> <td style="width: 10%;">Right</td> <td style="width: 10%;">• Yes</td> <td style="width: 10%;">• No</td> </tr> <tr> <td></td> <td>Left</td> <td>• Yes</td> <td>• No</td> </tr> </table>	Restricted Bending	• Yes    • No	Restricted Stooping	• Yes    • No	Restricted above shoulders	• Yes    • No	Restricted below shoulders	• Yes    • No	Simple Grasping	Right	• Yes	• No	Left	• Yes	• No	Pushing & Pulling	Right	• Yes	• No	Left	• Yes	• No	Fine Manipulation	Right	• Yes	• No	Left	• Yes	• No		Right	• Yes	• No		Left	• Yes	• No
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<p>VOCATIONAL ENVIRONMENT CONDITIONS: <i>(Check if contraindicated)</i></p> <table style="width: 100%;"> <tr> <td style="width: 33%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• Unprotected heights</li> <li>• Driving Automotive Equipment</li> <li>• Cold (below 40 degrees)</li> <li>• Heat (100 degrees or above)</li> </ul> </td> <td style="width: 33%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• Exposed to marked changes in temperature and humidity</li> <li>• Noise</li> <li>• Vibration</li> </ul> </td> <td style="width: 33%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• Being around moving machinery or other hazards</li> <li>• Exposure to dust, fumes &amp; gases</li> <li>• Noxious smells</li> <li>• Swing shift work hours</li> <li>• Other _____</li> </ul> </td> </tr> </table>			<ul style="list-style-type: none"> <li>• Unprotected heights</li> <li>• Driving Automotive Equipment</li> <li>• Cold (below 40 degrees)</li> <li>• Heat (100 degrees or above)</li> </ul>	<ul style="list-style-type: none"> <li>• Exposed to marked changes in temperature and humidity</li> <li>• Noise</li> <li>• Vibration</li> </ul>	<ul style="list-style-type: none"> <li>• Being around moving machinery or other hazards</li> <li>• Exposure to dust, fumes &amp; gases</li> <li>• Noxious smells</li> <li>• Swing shift work hours</li> <li>• Other _____</li> </ul>
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<p>PROGNOSIS FOR RETURN TO WORK:</p> <p>• Good      • Fair      • Poor</p>	<p>CONDITION IS:</p> <p>• Stable      • Slowly Progressive      • Chronic      • Acute</p>
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<p>WILL TREATMENT SUBSTANTIALLY IMPROVE FUNCTION OR EMPLOYABILITY?      • Yes      • No</p> <p>If Yes, how?</p> <div style="height: 60px; border: 1px solid black; margin-top: 5px;"></div>
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<p>PROGNOSIS:    Life expectancy: _____ Work Expectancy (Time): _____</p> <p>RECOMMEND: Consult, Treatment, Etc. (Specify) _____</p>
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<p>ADDITIONAL REMARKS:</p> <div style="height: 80px; border: 1px solid black; margin-top: 5px;"></div>
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***Please sign & date this form before returning to DVR counselor***

<p>Date of Exam: _____</p> <p>Physician Signature: _____</p> <p>Address: _____</p> <p>Phone: _____</p>
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**Return Completed Form to:**

<p>Counselor's Phone No: _____</p>
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