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| O:\WHS\Work\MISC\Images\HHSC-Logo Images\HHS_Logo_BW_S.jpg | Division for Rehabilitation Services**Pulmonary Evaluation Report** | **Form 3102** May 2017 |
| 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:      |
| **Consumer Data** |
| Name:      | Birth date:      | Social Security 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?       |
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|  | **Form 3102**Page 2 / 05-2017-E |
| **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** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **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:       |
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| **Form 3102**Page 3 / 05-2017-E |
| 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:      |