If you have a **Medical Condition or Physical Disability**, the following information will be helpful in determining eligibility.

1. Ask your doctor or treatment provider to complete the attached **Medical Information Form**.

2. If you have physical restrictions as a result of your disability, it would also be helpful to have your doctor or treatment provider complete one or both of the Functional Limitations Forms also included.

Any or all of these documents should be brought in at time of appointment. They may also be mailed or faxed directly to this office:

Ohio Rehabilitation Services Commission
617 Vine Street, Ste. 925
Cincinnati, Ohio 45202-2815

Phone: (voice) 513-852-3260 or 1-800-686-3323

Fax: **513/651-3309**

P:referral-intake/packet/medical form(rev 10-03)

MEDICAL INFORMATION FORM

Patient's name: ______________________________________ SSN: __________________

Diagnosis:

Prognosis:

Functional/Employment Limitations:

Medications/Treatment Plan:

Date patient was last seen by you?

____
Physician's Name (PLEASE PRINT)

____ ____________________
Physician's Signature Date

Please fax the form to: 513/651-3309 or mail it to:

REHABILITATION SERVICES COMMISSION
Bureau of Vocational Rehabilitation
617 Vine Street, Ste. 925
Cincinnati, Ohio 45202

P:referral-intake/packet/medical form rev 5/04

OHIO REHABILITATION SERVICES COMMISSION
BUREAU OF VOCATIONAL REHABILITIATION

Request for Physician's Report of Functional Limitations

In order for BVR to provide quality vocational rehabilitation services to our consumers, we need to identify the functional limitations of the individuals we serve. We need your help in doing so.

Important: Please respond to the questions below based on your professional findings only. While we recognize that your patients' opinions and subjective complaints are important, we need more concrete information if we are to help them succeed in finding appropriate employment.

RE:____ SSN:______________________________

DIAGNOSIS:______________________________ PROGNOSIS:______________________________

1. In an 8-hour workday, consumer can stand/walk:
   1 - 4 hours   4 _ - 6 hours   6 _ - 8 hours

2. In an 8-hour workday, consumer can sit:
   3 hours   3 _ - 5 hours   5 _ - 8 hours

3. Consumer can lift:
   up to 10 lbs   11 – 20 lbs   21 – 50 lbs   over 51 lbs

4. Lifting, as prescribed in #3, can be performed during the workday:
   occasionally   frequently   continually

5. Consumer can use feet for repetitive movements, i.e., operating foot controls:
   yes   no

6. Consumer is able to use hand for repetitive:

A. Simple Grasping	B. Pushing and Pulling	C. Fine Manipulation
yes no	yes no	yes no

7. Consumer is able to:

	Frequently	Occasionally	Not At All
A. Bend			
B. Squat			
C. Crawl			
D. Climb			
E. Push or Pull			

8. Consumer is able to reach above shoulder level: yes   no

REMARKS (on previously indicated limitations or other functional limitations to be considered in consumer's employment). If you need additional space for your remarks, please feel free to use the other side of this sheet.

PHYSICIAN'SIGNATURE:____ DATE:____________

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Case Management Resources