

**CHEYENNE AND ARAPAHO TRIBE OF OKLAHOMA  
VOCATIONAL REHABILITATION PROGRAM  
REPORT OF PHYSICIAN'S EXAMINATION**

Patient Identification:

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

Case Number: \_\_\_\_\_

Relevant Medical

History: \_\_\_\_\_

\_\_\_\_\_

Present Complaints: \_\_\_\_\_

Present Medication(s): \_\_\_\_\_

\_\_\_\_\_

Physical Findings:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse Rate: \_\_\_\_\_

Respiration: \_\_\_\_\_ Systolic: \_\_\_\_\_ Diastolic: \_\_\_\_\_

HEENT (head, ears, nose, throat): \_\_\_\_\_

Neck: \_\_\_\_\_

Abdominal and Pelvic: \_\_\_\_\_

Auditory: \_\_\_\_\_

Heart and Circulatory System: \_\_\_\_\_

Lungs: \_\_\_\_\_

Orthopedic: \_\_\_\_\_

Neurological: \_\_\_\_\_

Visual: \_\_\_\_\_

Other Significant Findings: \_\_\_\_\_

\_\_\_\_\_

Please complete the following in regards to the severity of the client's disability

PRIMARY MEDICAL DIAGNOSIS: \_\_\_\_\_  
\_\_\_\_\_

Are any additional specialist's examination needed? \_\_\_\_\_

In your opinion, is medical or corrective surgical treatment recommended? \_\_\_\_\_

If so, Please Identify: \_\_\_\_\_  
\_\_\_\_\_

Please identify the pertinent functional limitations this client has as a result of the disability: (Check all that apply and make comments as necessary)

\_\_\_\_\_ VISUAL Rt eye \_\_\_\_/\_\_\_\_ Lt eye \_\_\_\_/\_\_\_\_ both eyes \_\_\_\_\_  
Corrected \_\_\_\_/\_\_\_\_ Corrected \_\_\_\_/\_\_\_\_ Corrected \_\_\_\_\_

\_\_\_\_\_ HEARING \_\_\_\_\_

\_\_\_\_\_ SPEECH \_\_\_\_\_

\_\_\_\_\_ AMBULATION AND MOBILITY \_\_\_\_\_

\_\_\_\_\_ UPPER EXTREMITY FUNCTIONING \_\_\_\_\_

\_\_\_\_\_ HAND FUNCTIONING \_\_\_\_\_

\_\_\_\_\_ COORDINATION (specify) \_\_\_\_\_

\_\_\_\_\_ CAPACITY OF EXERTION/ENDURANCE \_\_\_\_\_

\_\_\_\_\_ MOTOR SPEED \_\_\_\_\_

\_\_\_\_\_ STABILITY OF CONDITION \_\_\_\_\_

Are there any restrictions of self-care? \_\_\_\_\_

PROGNOSIS AND RECOMMENDATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name and address of Examining Physician

Date of examination: \_\_\_\_\_

Date of Report: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_