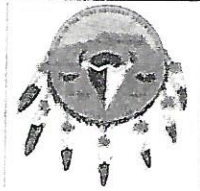


Fort Belknap Vocational Rehabilitation Program

656 Agency Main Street Harlem, MT 59526

(406) 353-8359 Phone (406) 353-4572 Fax



REFERRAL TO THE FORT BELKNAP

VOCATIONAL REHABILITATION PROGRAM

Consumer Name:		Phone Number:	
Current Mailing Address:		Date of Birth:	
County Residence:			

Are you a member of a federally recognized tribe? Yes No Name of Tribe:

Do you receive SSI or SSDI benefits? YES NO If yes, please attach documentation

Are you currently on a CDC treatment plan? YES NO If yes, please attach documentation

(Provider/Physician fill out section below):

Date of Referral:		Referral Made By:	
Agency Referring:		Agency Phone #:	

Does the consumer have a physical or mental disability? Yes No Please describe disability.

Has the disability kept the consumer from attaining/maintaining gainful employment? Please describe.

Does the consumer want to enter/re-enter gainful employment? Please describe.

Has the consumer received vocational rehabilitation services in the past? YES NO

If YES, with what agency?

Reason for referral:

Date received by FBVR: _____ Referral taken by: _____

**FORT BELKNAP
VOCATIONAL REHABILITATION**

656 Agency Main Street
Harlem, MT 59526
Business Phone: 353-8359
Business Fax: 353-4572

GENERAL MEDICAL EXAM

The below named person has applied to the Fort Belknap Tribe Vocational Rehabilitation Program for services. This medical examination is necessary if the applicant is found to be eligible for services.

IDENTIFICATION:

_____	_____	____/____/____	<u>M or F</u>
LAST NAME	FIRST NAME	D.O.B	SEX
_____	_____	_____	_____
STREET ADDRESS	CITY	STATE	ZIP

My disability (ies) is/are:

(Medical Professionals complete the rest of the document)

HISTORY OF GENERAL HEALTH (other than major disability). Include any family history which might be an influence on patient's mental or physical health.

PHYSICAL LIMITATIONS: Check if any problems with the following:

a. Sit	<input type="checkbox"/>	f. Sight	<input type="checkbox"/>
b. Stand	<input type="checkbox"/>	g. Hearing	<input type="checkbox"/>
c. Lift	<input type="checkbox"/>	h. Memory	<input type="checkbox"/>
d. Bend	<input type="checkbox"/>	i. Speech	<input type="checkbox"/>
e. Respiratory	<input type="checkbox"/>	j. Other	<input type="checkbox"/>

ANALYSIS OF MAJOR DISABILITY:

- A. Nature of Disability (ies):

- B. Etiology and time of onset:

- C. History of previous diagnostic study and treatment of major disability: _____

- D. Status of disability (ies) at present time (circle one): Improving Worsening
Static
- E. Is complete restoration of function (circle one): Probable Improbable
If probable, what is the anticipated date of recovery:

- F. Has patient's past health, in general, been (circle one): Good Fair Poor

PHYSICAL EXAMINATION:

- A. **General appearance** (i.e. mental attitude, physique, gait, bodily vigor etc.):

- B. **Weight:** _____ **Height:** _____ **Temperature:** _____
- C. **Vision: without glasses** 20/left _____ 20/right _____ **corrected** 20/left _____ 20/right _____
Color Blind: _____
- D. **Hearing:** (Ordinary Conversation) Right _____ Left _____
- E. **Blood Pressure:** Syst. _____ Dyst. _____
- F. Indicate **POSITIVE** findings in regard to any of the following areas, and **DESCRIBE IN THE SPACE BELOW:**

Head and Neck: _____	Thorax: _____
Ano-Rectal: _____	Uro-Genital: _____
Extremities: _____	Nervous System: _____
Orthopedic: _____	Abdomen: _____
Pelvic: _____	Skin: _____
Other: _____	
- G. Laboratory Test (Based on CPT IV)
No. 85018 Blood Hemoglobin, Photoelectric or No. 85014
Hematocrit _____
Albumin _____ Spec. Gr _____ Sugar _____
Microscopic and other _____

SUMMARY: (Your opinions will be a factor in determining eligibility for rehabilitation services.)

A. Do you feel this examination is complete enough to adequately determine the nature and extent of the major disability and general physical condition?

B. Should the patient be referred to a specialist?

C. Degree of residual function in structure affected by major disability?

D. Can this residual function be substantially improved by any form of medical, surgical, or physical therapy?

If so, what are your recommendations?

E. Prognosis as to longevity and general health

F. What are your recommendations as to functional limitations in patient's activities and working conditions?

G. Remarks: Please give any additional information that will be helpful in evaluating the physical and vocational potential of this person.

Date Of Examination

Signature

Title

**FORT BELKNAP
VOCATIONAL REHABILITATION**

**PSYCHOLOGICAL/PSYCHIATRIC
CONSULTANT'S WORKSHEET**

Name: _____ Age: _____ Sex: _____

Primary Disability at Application: _____

Secondary Disability at Application: _____

Vocational Objective (If Known): _____

What is the date of the last exam (for the condition) that the client is being referred for:

1. The **PSYCHOLOGICAL/PSYCHIATRIC** evidence presented is recent enough to be adequate and meaningful: Yes No*

If No, I recommend the following specialist examination be obtained: _____

2. Major Diagnosis Defined: _____

Secondary Diagnosis Defined: _____

3. IDENTIFIABLE **PSYCHOLOGICAL/PSYCHIATRIC** functional limitations(s) or impediment(s) is/are as follows:

PSYCHOLOGICAL/PSYCHIATRIC Consultant's Signature

Date