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: _____

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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:

LAST NAME	FIRST NAME	___/___/___ D.O.B	M or F 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	☐	f. Sight	☐
b. Stand	☐	g. Hearing	☐
c. Lift	☐	h. Memory	☐
d. Bend	☐	i. Speech	☐
e. Respiratory	☐	j. Other	☐

ANALYSIS OF MAJOR DISABLITITY:

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