State of Illinois
Department of Human Services - Division of Rehabilitation Services

VR FUNCTIONAL LIMITATION REPORT

An Authorization to Use/Disclose Medical and Confidential Information (IL488-1111W) must accompany this form

To: Dr. _____ Date: _____

Address: _____ Return to: _____

_____ _____

Fax: _____ Fax: _____

Phone: _____ Phone: _____

The customer identified below has applied for **vocational rehabilitation services** to assist with employment and has provided authorization to request information concerning their diagnoses and functional limitations.

Name of Customer: _____ Date of Birth: _____

Signature of Customer: _____ Date: _____

Please list all diagnoses including temporary medical conditions and/or recent injuries:

Physical: _____

Psychiatric: _____

Cognitive: _____

Behavioral: _____

FUNCTIONAL LIMITATIONS Please check appropriate response: (Y = yes; N = no; U = unknown)

Physical	Y	N	U	Cognitive	Y	N	U	Psychiatric Behavioral	Y	N	U
Weakness	☐	☐	☐	Impaired ability for new learning	☐	☐	☐	Impaired insight	☐	☐	☐
Fatigue	☐	☐	☐	Impaired ability to retain information	☐	☐	☐	Impaired judgment	☐	☐	☐
Poor Trunk control	☐	☐	☐	Impaired ability to self-initiate tasks	☐	☐	☐	Compulsive behaviors	☐	☐	☐
Fine motor impairment	☐	☐	☐	Impaired insight	☐	☐	☐	Poor impulse control	☐	☐	☐
Can't bend	☐	☐	☐	Impaired judgment	☐	☐	☐	Hallucinations	☐	☐	☐
Abnormality of gait	☐	☐	☐	Inability to stay on task	☐	☐	☐	Reduced concentration	☐	☐	☐
Short of breath	☐	☐	☐	Impaired expressive language	☐	☐	☐	Mood swings	☐	☐	☐
Lifting restriction # lbs? ___	☐	☐	☐	Impaired receptive language	☐	☐	☐	Impaired organizational skills	☐	☐	☐
Can't stoop	☐	☐	☐	Confusion	☐	☐	☐	Low motivation	☐	☐	☐
Impaired balance	☐	☐	☐	Confabulation	☐	☐	☐	Disassociation	☐	☐	☐
Dizziness	☐	☐	☐	Environmental Disorientation	☐	☐	☐	Lack of energy	☐	☐	☐
Limited weight bearing	☐	☐	☐	Lacks Awareness of Environment	☐	☐	☐	Substance abuse	☐	☐	☐
Limited Range of Motion	☐	☐	☐	(Which extremity?)							
Sensory Impairment	☐	☐	☐	(Identify)							

Is the customer's disability? (check all that apply):

Acute	☐	Stable	☐	Rapidly Progressive	☐
Recurrent	☐	Slowly Progressive	☐	Permanent	☐

Comments: _____

Are there any issues related to employment? _____

_____ _____ _____

Printed Name of Physician or Authorized Representative | Signature of Physician or Authorized Representative | Date