Rehab Professionals of Cleveland, Inc.

Request for Functional Testing

Evaluee Name ______________________________________ DOB ___________________

___ Please Contact Evaluee to schedule test via: ___ phone ____________________
___ mail ____________________

___ Evaluee has been notified of exam time and location ___________ __________ ___________
Date Time Location

Test Requested ___ Comprehensive FCE ___ Job Specific FCE ___ Post Offer Fitness Screen

Job Title ____ ___ Not Applicable

Employer____ ___ Not Applicable

Report Recommendations (Check all that Apply)
___ Level of Work (i.e., Sedentary, Light, Medium, Heavy, Very Heavy)
___ Meets Criteria for Indicated Job
___ Rehab Potential
___ Work Restrictions
___ Maximum Medical Improvement
___ Consistency of Effort

Report Distribution to: Report requested by date: ______________________
___ Requestor
___ MCO Case Manager
___ Physician of Record
___ Vocational Case Manager
___ Third Party Administrator
___ Employer
___ Other ____

Payment Source: **Claim Number:** ____
___ Employer
___ BWC Claim
___ Vocational Rehabilitation Plan
___ Federal Workers' Compensation
___ Attorney
___ Test Subject
___ Other ____

Requested by: ____________________________________ phone: _____________________

E-mail: ____ fax: ______________________

Fax to: 440-546-8280 or email to: rehabprosbh@rehabpros.net

For Information call: 440-526-8566 www.rehabpros.net