

INITIAL EVALUATION SUMMARY

Claims Administrator:

Employee:

Address:

Claim #:

DOI:

City/State/Zip:

Employer:

Contact Name:

Date of Initial Evaluation:

Reason for Referral:

Full Service

Evaluation Only

Initial Meeting and Impressions: Vocationally Feasible? Yes No Deferred (Explain)

Summary:

Recommendations:

Plan of Action:

Next Reporting Date:

QRR (Print Name):
Telephone:

Signature:

Date:

Attachments:

a) Data Sheet _____

b) _____

c) _____

d) _____

Copies Sent To:

a) _____

b) _____

c) _____

d) _____

INITIAL EVALUATION DATA SHEET

PERSONAL INFORMATION: Name:

Male:	Female:	Social Security No.:	DOB:
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Phone No.:	CA Driver's License No.:	Exp. Date:
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License Restrictions (Explain):

Distance willing to travel to work (one way):	Areas willing to drive:
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Reliable vehicle available for transportation (full-time): _____ Yes _____ No
 If no, what method of transportation will be used?:

Willing to relocate? Yes No	Work Shifts: All Days All Shifts M-F Only 8-5 Only
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Describe issues which may interfere with employee's participation in services:

SOCIO-FAMILY FINANCIAL HISTORY

Marital status: Married Single Divorced Widowed Separated

Number of Dependents Living at Home:	Ages:	Child Support Payments? ___ Yes ___ No Amount: \$
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Child care required: Yes No	Estimated amount per week: \$
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Able to financially support self throughout duration of services: ___ Yes ___ No (Explain):

Receiving VRMA? Yes No	Amount per week: \$
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Receiving PD Supplement? Yes No	Amount per week: \$
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Other sources of income (explain):

EDUCATIONAL BACKGROUND

High School Graduate? ___ Yes ___ No Year: _____	Name & Location of High School:
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If not HS graduate, GED? ___ Yes Year: _____ If No GED - Last grade completed:	Post-HS Studies: ___ Certificate ___ AA/AS ___ BA/BS Area of Study: _____ Year: _____
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English Language Speak ___ Yes ___ No Read ___ Yes ___ No Level _____ Write ___ Yes ___ No Level _____	Other Language: _____ Speak ___ Yes ___ No Read ___ Yes ___ No Write ___ Yes ___ No
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Employee's List of Perceived Work Skills:

MILITARY SERVICE: Dates of Service:

Branch:

Special Skills:

VOCATIONAL HISTORY

Company, Location	Dates Employed		Job Title	Salary	Reason for Leaving
	From	To			

MEDICAL FILE REVIEW

Treating Physician:

Phone:

Address:

Medical Restrictions:

Permanent & Stationary

Yes

No

Date:

Medical Restrictions/Limitations (specify medical report and date relied upon):

Current Medications (specify medical report and date relied upon):

Currently in Physical Therapy: _____ Yes _____ No Days/Times:

Non-Industrially Related Medical Conditions (explain):

PRESENT PHYSICAL TOLERANCES (Subjective)

Sitting _____ minutes

Lifting _____ # of Pounds: _____

Reaching

Standing _____ minutes

Climb Steps: Can _____ Cannot _____

Below shoulder _____ Yes _____ No

Driving _____ minutes

Bending: Can _____ Cannot _____

At shoulder _____ Yes _____ No

Walking _____ minutes

Dominant Hand: Rt. _____ Lft. _____

Handling/Feeling _____ Yes _____ No

Pushing/Pulling _____ Yes _____ No

Vision Restriction _____ Yes _____ No

Ready to Return to Work _____ Yes _____ No

Supplemental Medical/Physical Information:

VOCATIONAL CONSIDERATIONS

Preliminary Assessment of Transferable Skills:

Client's Expressed Interest/Expectations of Vocational Rehabilitation:

Observations (Comments on Appearance, Rapport, Cooperation, Attitude):

VOCATIONAL FEASIBILITY FACTORS

Can the employee reasonably benefit from the provision of vocational rehabilitation services?

INVESTIGATION OF MODIFIED/ALTERNATIVE EMPLOYMENT

<input type="checkbox"/>	Available	Contact:
<input type="checkbox"/>	Not Available	Title:
<input type="checkbox"/>	Unknown/Not Requested	Date of Conduct:

**EXPLANATION OF VOCATIONAL REHABILITATION PROCESS
(Check Box For All Issues Covered With Employee)**

<input type="checkbox"/>	EE Role	<input type="checkbox"/>	Caps/Limits on VR	<input type="checkbox"/>	Termination Process
<input type="checkbox"/>	QRR Role	<input type="checkbox"/>	VRMA	<input type="checkbox"/>	Reinstatement Process
<input type="checkbox"/>	Carrier/ER Role	<input type="checkbox"/>	Dispute Resolution Process	<input type="checkbox"/>	Interruption Process
<input type="checkbox"/>	Rehab Unit Role	<input type="checkbox"/>	Effect of Delays	<input type="checkbox"/>	Allowable Costs
<input type="checkbox"/>	Help RTW Brochure	<input type="checkbox"/>	Plan Definition	<input type="checkbox"/>	Nature, Extent Added Costs
<input type="checkbox"/>	Plan Hierarchy	<input type="checkbox"/>	Plan Parameters	<input type="checkbox"/>	Other (Explain)

**Rehabilitation Unit
California Division of Workers' Compensation**

Form RU-120

**INITIAL EVALUATION
SUMMARY**

Purpose:

To document the findings and recommendations of the Qualified Rehabilitation Representative who conducts the initial evaluation. Per AR §10132.1, such assessment is to include an initial assessment of the worker's ability to benefit from VR services.

Submitted by:

Qualified Rehabilitation Representative (QRR).

When submitted:

The Rehabilitation Unit encourages an expeditious assessment of employee skills and vocational feasibility. The RU-120 should be submitted not later than 30 days from completion of the initial interview unless otherwise agreed to.

Where submitted:

To the claims administrator with copies to all parties. If the QRR is functioning as an Independent Vocational Evaluator (IVE), the RU-120 would be filed directly with the Rehabilitation Unit with copies to all parties.

Form completion:

This form is to be completed by the QRR. The purpose of the form is to obtain comprehensive, yet concise, information which is critical for assessing vocational feasibility and developing an appropriate plan per the California Standards Governing Timeliness and Quality of Vocational Rehabilitation Services. Information gathered for each section must fit within the section designated for that category and the typeface must be no smaller than 10 point. The cost of additional or more detailed reports shall be borne by the party requesting them.

Accompanying documents:

None

Rehabilitation Unit action:

None.

Copy:

All parties.