



Diabetes or Glucosuria
Medical Follow-Up

Patient's Name: _____ DOB: _____

Dear Doctor:

The employee named above was seen by our staff for a work related examination. In order for an Industrial Employee or driver of a Commercial Motor Vehicle to obtain or maintain certification when a medical condition is present, the patient must obtain medical follow-up from his/her personal physician documenting that the condition is diagnosed, treated, and under control.

The employee has been informed of the rationale for this follow-up request. By signing below, he/she gives approval to WorkFit Medical LLC to share documentation concerning this case with his/her personal physician.

We thank you in advance for completing this form and faxing it back to WorkFit Medical LLC at the clinic listed below.

Employee Signature: _____ Date: _____

Comments/Conditions: Diabetes or Glucosuria

- Dipstick Urinalysis shows glucosuria (_____)
Patient carries the diagnosis of diabetes. Please comment on stability AND include most current lab results.

Requested by: _____

Please Complete and Verify:

- 1. The above named patient is under my medical supervision for the above condition and has been seen at my office within the last 6 months.
2. Is the patient diabetic?
3. Has the condition been addressed or treated and stabilized?
4. Current Treatment (If Medications, please attach list)
5. Is the patient compliant with treatment?
6. Within the past two (2) years, have there been any episodes of hypo or hyperglycemia that have required emergency treatment?
7. In your opinion, can the above stated patient safely work without restrictions?

Comments: _____
8. Does this patient have any other condition, which would interfere with his/her ability to work?
If Yes, what? _____

Doctor's Signature: _____ Date: _____
Printed Name: _____ Phone: _____
Office Address: _____ Fax: _____

Workfit Use Only
Date Reviewed: _____
Provider Signature: _____
Employee meets follow-up requirements for ___ months.
Employee does not meet follow-up requirements
Other: _____

Must Be Returned to WorkFit in 30 Days

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