WorkFitMedical
Occupational Health Services

Commercial Driver
Medical Follow-Up Form
Hypertension

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 a 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 one of the fax numbers listed below.

Employee Signature _____ Date: _____

Comments/Conditions: **Hypertension**

☐ Physical Examination shows elevated Blood Pressure: _____/_____ , _____/_____ , _____/_____

☐ Patient carried the diagnosis of HTN. 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. Yes_____ No_____ Date of last visit:_____
2. Has the patient been diagnosed with HTN? Yes ___ No ___ **Blood Pressure at last visit _____/_____**
3. Has the condition been addressed or treated and stabilized? Yes ____ No____
   (If no, please comment on stability of the condition) _____
4. Current Treatment (if medications, please attach list) _____
5. Is patient compliant with treatment? Yes ____ No____
6. In your opinion, can the above stated patient safely work without restrictions? Yes ____ No ____
   Comments:_____
7. Does this patient have any other condition which would interfere with his/her ability to work?
   Yes ____ No ____ (if yes, what?) _____

Doctor's Signature:_____ Date:_____
Doctor's Printed Name:_____ Office Phone:_____
Office Street Address:_____ Office Fax:_____
City:_____ State:_____ Zip:_____

(WorkFit use only)

Date Reviewed: _____

Provider Signature: _____

☐ Employee meets follow-up requirements for ____ months.

☐ Employee does not meet follow-up requirements.

☐ Other: _____

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