WorkFitMedical
Occupational Health Services

# Firefighter Medical Follow-Up Form
## Hypertension

Patient's Name: _____ DOB: _____

**Dear Doctor:** The employee named above was seen by our staff for a Firefighting Clearance Examination. In order for a Firefighter 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: _____

*****Must be filled out and returned by _____*****

**(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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