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. ☐ Yes ☐ No Date of Last Visit: _____
2. Is the patient diabetic? ☐ Yes ☐ No Last HgbA1C Results: _____ Date Drawn: _____

Has the condition been addressed or treated and stabilized? Yes ☐ No ☐

If No, please comment on stability of the condition: _____

Current Treatment (If Medications, please attach list) _____

Is the patient compliant with treatment? Yes ☐ No ☐

Within the past two (2) years, have there been any episodes of hypo or hyperglycemia that have required emergency treatment? ☐ Yes ☐ No

In your opinion, can the above stated patient safely work without restrictions? Yes ☐ No ☐

Comments: _____

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: _____
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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