Sleep Disorders
Residual Functional Capacity Questionnaire

Name:	
Claim #:	
Date of Injury:	
Please Print Name of Medical Evaluator:	
Medical Specialty:	
What is the first date patient's impairment(s) became "severe" meaning that his/her impairment(s) caused interference ADL's or ability to work?	Date:
When did you begin treating the patient?	Date:
How frequently do you see your patient?	Date:

Identify your patient's **symptoms and signs**:

☐ Cataplexy ☐ Sinus arrhythmia ☐ Hypnogogic phenomenon
☐ Insomnia ☐ Extreme bradycardia ☐ Ventricular tachycardia
☐ Atrial flutter ☐ Sleep paralysis ☐ Excessive daytime sleepiness
☐ Cognitive problems ☐ Automatic behavior ☐ Hypercapnia
☐ Hypoxia ☐ Pulmonary insufficiency ☐ Obesity
☐ Sleep apnea: A. ☐ obstructive B. ☐ central C. ☐ mixed
☐ Other: _____

Does your patient exhibit **recurrent daytime sleep attacks**? ☐ Yes ☐ No
If yes,

A. Can these attacks occur suddenly and in hazardous conditions (e.g., driving, while exposed to heights or moving machinery)? ☐ Yes ☐ No

B. **How often** do these **attacks** typically occur: _____ per day or _____ per week or _____ per month

C. For **how long** does your patient typically sleep with each attack?_____

D. Identify situations that can precipitate attacks:

☐ Quiet ☐ Sleep disturbance ☐ Exertion ☐ Repetitive activity

☐ Side affects of medications ☐ Other_____

If your patient was working and has a sleep attack, would the attack likely disrupt the work of coworkers or supervisors in your patient's vicinity? ☐ Yes ☐ No

Is there a reasonable medical probability that claimant will need to take unscheduled breaks from work activity during the workday? ☐ Yes ☐ No ☐ Other:

What symptom(s) cause a need for breaks?

☐ Daytime sleep attacks
☐ Chronic fatigue
☐ Adverse effects of medication
☐ Other:_____

How often during a typical workday will claimant experience fatigue or other symptom severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks as a result of the combination of impairments?

Not at all	**Rare** 1-5% day	**Occasionally** up to 1/3rd day	**Frequently** 1/3rd to 2/3rd day	**Continuously** 2/3rd day or more
☐	☐	☐	☐	☐

How often during a typical workday will the combination of claimant's of impairments interfere with an ability to perform ***sustained and competitive work***?				
Not at all	**Rare** 1-5% day	**Occasionally** up to 1/3rd day	**Frequently** 1/3rd to 2/3rd day	**Continuously** 2/3rd day or more
☐	☐	☐	☐	☐

To what degree can claimant tolerate ***work stress*** as a result of the medical condition(s)?	
Examples of factors that may precipitate work related stress: maintaining speed; precision; persistence and pace; complexity; meeting deadlines; working within a schedule; making decisions; exercising independent judgment; completing tasks; getting to work regularly; remaining at work for a full day.	
☐ Incapable of "low stress" jobs	☐ Capable of low stress jobs
☐ Moderate stress is okay	☐ Capable of high stress work
Will claimant's impairments likely to produce "good days" and "bad days"? ☐ Yes ☐ No ☐ Other:	
If yes, please estimate, on average, how many days per month claimant is likely to be absent from work as a result of the impairments or treatment?	
☐ Never ☐ About three days per month ☐ About one day per month	☐ About two days per month ☐ About four days per month ☐ More than four days per month

How often and/or how long if at all, will the patient experience mental fatigue that manifests in somnolence (decreased wakefulness)?
Frequency of episodes: Duration of episodes: Second/Minutes:

How often and/or how long if at all, will the patient experience mental fatigue that manifests in general decrease of attention, not necessarily including sleepiness?
Frequency of episodes: Duration of episodes: Second/Minutes:

How often and/or how long if at all, will the patient experience episodes micro-sleep that may last for a fraction of a second or up to thirty seconds?
Frequency of episodes: Duration of episodes: Second/Minutes:

How often and/or how long if at all, even in the middle of lively conversations, will the patient experience an onset of a micro sleep episode resulting in 'suddenly' losing the thread of a conversation?
Frequency of episodes: Duration of episodes: Second/Minutes:

In utilizing this form, please assume the following definitions:

1. "Mild" assumes an annoyance but no reduction in the ability to perform the function.
2. "Severe" assumes an inability to perform the function.
3. Please assume that "off task" means an inability and/or a reduction in productivity over the course of a work day, 8 hours or otherwise. If appropriate, please choose <u>one</u> of the 4 following definitions of **"Moderate"** you feel best describes claimant's functional limitations, if any:
    1. ☐ Will be "off task" up to 10% of the time in an 8 hour day;
    2. ☐ Will be "off task" up to 15% of the time in an 8 hour day;
    3. ☐ Will be "off task" up to 20% or more of the time in an 8 hour day;
    4. ☐ Other: Will be "off task" of the time in an 8 hour day.

	Mild	Moderate	Severe	No Evidence of Limitation in this Category
Able to perform tasks that require constant concentration, such as driving a vehicle to and from work.	☐	☐	☐	☐
Able to perform tasks that require constant concentration, such as driving a vehicle during work.	☐	☐	☐	☐

Able to perform tasks that require constant concentration, such as operating machinery, equipment or electric operated tools.	☐	☐	☐	☐
The ability to maintain concentration and attention for extended periods (the approximately 2-hour segments between arrival and first break, lunch, second break, and departure).	☐	☐	☐	☐
The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	☐	☐	☐	☐
The ability to work in the proximity of and be aware of normal hazards and take appropriate precautions.	☐	☐	☐	☐
Complete a normal workday and workweek without interruptions from symptoms and perform at a consistent pace without an unreasonable number and length of rest periods.	☐	☐	☐	☐

Please describe any other limitations that would affect your patient's ability to work at a regular job on a sustained basis or any testing that would help to clarify the severity of your patient's impairment(s) or limitations:

_____

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the report accurately describes the information provided to me and except as noted herein, that I believe it to be true. I also declare under the perjury that this physician has no violated section 139.3 of the Labor Code.

Signature of Physician_____ Date _____