VISION RFC

Name:	
Claim #:	
Date of Injury:	

Please Print Name of Medical Evaluator:	
Medical Specialty:	
What is the first date claimant's impairment(s) became "severe" meaning that they caused interference in ADL's or ability to work?	Date:
When did you begin treating the claimant?	Date:
How frequently do you see your claimant?	Date:
Diagnosis:	
Prognosis:	

Visual acuity after best correction:	Right Eye:	
	Left Eye:	

Describe any contraction of peripheral visual fields:

Describe patient's visual ***symptoms***:

As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a ***competitive work situation****:*

a. How often can your patient perform work activities involving the following?

	Not at all	**Rarely** 1-5% day	**Occasionally** up to 1/3rd day	**Frequently** 1/3rd to 2/3rd day	**Continuously** 2/3rd day or more
Near Acuity					
Far Acuity					
Depth Perception					
Accommodation					
Color Vision					
Field of Vision					

b. Is your patient capable of avoiding ordinary hazards in the workplace, such as boxes on the floor, doors ajar, approaching people or vehicles? ☐ Yes ☐ No

c. Does your patient have any difficulty walking up or down stairs? ☐ Yes ☐ No

d. Can your patient work with small objects such as those involved in doing sedentary work? ☐ Yes ☐ No

e. Can your patient work with large objects? ☐ Yes ☐ No

f. Does your patient have to wear tintied glasses to protect his/her eyes from glare? ☐ Yes ☐ No
If yes, how dark should the glasses be? Lightly tinted ☐ moderately tinted ☐ dark ☐

g. If your patient must wear tinted glasses will the tinting reduce your patient's capacity to work with small item? ☐ Yes ☐ No

h. Is it medically probable that your patient may be suffering from depression or anxiety as a result of his/her vision loss/reduction? ☐ Yes ☐ No
If yes, please describe in your own words how your patient's vision loss may be affecting him/her emotionally:

Does your patient have exertional or postural limitations related to vision problems? ☐ Yes ☐ No

If yes, how many pounds can your patient lift and carry?

	Not at all	**Rarely <5 Min**	**Occasionally up to 1/3rd day**	**Frequently 1/3rd to 2/3rd day**	**Continuously 2/3rd day or more**
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
26-50 pounds					

i. How often can your patient perform the following activities?

	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
Stoop (bend)					
Crouch/squat					
Climb ladders					

Is there a medically probability your patient will experience the following symptoms with when performing tasks requiring near acuity:

	Not at all	**Rare**	**Occasionally**	**Frequently**	**Continuously**
Headaches					
Nausea					
Vertigo					
Eye Strain					
Blurry vision					
Tearing					
Other:					

Please describe any other limitations or difficulties, if any, that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

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.

My opinions are expressed to a degree of medical probability, unless otherwise stated.

Signature of Physician_____ Date _____