CARDIAC RESIDUAL FUNCTIONAL CAPACITY

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:	
Within a reasonable degree of medical probability:									
Can the claimant reasonably be expected to engage in sustained competitive work 8 hours a day 5 days a week taking into account the totality of his/her functional limitations?								☐ Yes	☐ No
How many hours can claimant reasonably expect to sustain competitive work if vocationally and medically compatible work is indentified? Hour(s) each day:	<1	1	2	3	4	5	6	7	8

Identify all of your patient's *symptoms*:		
☐ chest pain	☐ edema	☐ angina equivalent pain
☐ nausea	☐ shortness of breath	☐ palpitations
☐ fatigue	☐ dizziness	☐ weakness
☐ sweatiness	☐ Other:	
If your patient has anginal pain, please respond to questions a, b, c and d below:		
(a). Frequency: ☐ Daily ☐ Once or more a week ☐ Once or more a month ☐ Other		
(b). Precipitating factors: ☐ At rest; ☐ With some physical exertion ☐ With moderate physical exertion; ☐ Only with extreme physical exertion.		
(c). Severity of this pain: ☐ Minimal; ☐ Slight ☐ Moderate ☐ Severe ☐ Other:		
(d). Can the pain prevent your patient from performing a competitive level of work: ☐ Yes ☐ No		

Does your patient exaggerate, magnify or embellish his/her symptoms?	☐ Yes	☐ No
Does your patient have *marked limitation of physical activity*, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though your patient is comfortable at rest?	☐ Yes	☐ No
Do emotional factors contribute to the severity of your patient's subjective symptoms and functional limitations?	☐ Yes	☐ No

How often is your patient's experience of cardiac symptoms (including psychological preoccupation with his/her cardiac condition, if any) severe enough to interfere with attention and concentration?	**N/A** ☐	**Rarely** (1-5% day) ☐	**Occasionally** (up to 1/3rd day) ☐	**Frequently** (1/3rd to 2/3rd day) ☐	**Continuously** (2/3rd day or more) ☐

Are your patient's impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in this evaluation?	☐ **Yes**	☐ No
If no, please explain:		

EXERTIONAL PHYSICAL DEMANDS: (SIT, STAND, WALK)

How many hours of a work day, 8 hours or otherwise, can claimant be expected to sustain competitive work:

	<1	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Sit									
Stand									
Walk									
Drive									

EXERTIONAL PHYSICAL DEMANDS (LIFT, CARRY, PUSH AND PULL)

	LIFT				
	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					
	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					
	PUSH/PULL				
	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					

NON-EXERTIONAL PHYSICAL DEMANDS

	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
Climb Ladders					
Climb Stairs					
Climb Poles					
Balance					
Kneel					
Stoop					
Crouch					
Crawl					
Reaching Over shoulder/head					
Reaching Below shoulders					
Handling					
Fingering					
Feeling					

SIDE EFFECTS OF MEDICATION

Please list medications for the industrial condition(s), if any?			
Is there a reasonable medical probability that claimant will experience side effects from the industrial medication(s)? ☐ Yes ☐ No ☐ Other:			
What side effect(s) are likely to occur, if any?			
Sweating		Dry Mouth	
Weight Loss		Depression	
Drowsiness		Feeling weak	
Difficulty maintaining concentration		Dizziness	
Reduced short term memory		Confusion	
Constipation		Low Energy	

Mental/Mood Changes		Headaches		
Blurry Vision		Trouble Sleeping		
Nausea		Loss of Appetite		Other
Vomiting		Diarrhea		Other
Sedation		Weight Gain		Other

Will the claimant experience *fatigue* due to the side effects from the medication? YES ☐ NO ☐

Please list medications for non-industrial condition(s), if any?

Is there a reasonable medical probability the claimant will experience side effects from non-industrial medication(s), if any?
☐ Yes ☐ No If yes, please explain:

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 one of the 4 following definitions of **"Moderate"** you feel best describes claimant's functional limitations taking into account the side effects of the medication(s), 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.

To what degree will the side effects impair claimant's ability for concentration, persistence pace *separate and apart* from the underlying industrial medical condition(s)?
☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other:

To what degree will the side effects impair claimant's ability for concentration, persistence and pace in *combination* with the underlying industrial medical condition(s)?
☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other:

When side effects exist can you estimate the severity?
☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other:

Hours	<1	2	3	4	5	6	7	8
Approximate duration of the most severe side effect(s):								

Is claimant allowed to operate machinery or motorized vehicles when experiencing side effects from the medication?
☐ Yes ☐ No ☐ Other:

Is there a reasonable medical probability that the side effects will reduce claimant's ability to perform work to a minimum standard of productivity while working? If yes, to what degree:
☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other:

Is there a reasonable medical probability that the side effects will reduce claimant's ability to perform detailed work requiring hand/eye coordination? If yes, to what degree:
☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other:

Is there a reasonable medical probability that the side effects will reduce claimant's cognitive acuity and/or ability to focus on activities such as reading, writing, computer use? If yes, to what degree:
☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other:

Is there a reasonable medical probability claimant's *fatigue,* if any, due to the combined effects of his or her medical condition(s), will reduce his or her exertional capacity to sit, stand, walk, lift, carry, push and/or pull?
☐Yes ☐ No ☐ Other:

REASONABLE ACTIVITES TO CONTROL AND/OR RELIEVE THE EFFECTS OF CARDIAC CONDITION

What is the most effective manner for claimant to control or manage his/her **cardiac condition?**

☐ Take Medications	☐ Apply hot/cold packs	Other:
☐ Apply TENS Unit	☐ Alternate positions	
☐ Lie Down	☐ Avoid prolonged activities	
☐ Recline	☐ Use of supports	
☐ Rest	☐ Avoid offending activities	

Allowance to alternate positions:

A. Will claimant need an allowance to alternate positions at will?	YES☐	NO☐	Comments:
B. Will the allowance be restricted to sit/stand at will?	YES☐	NO☐	
C. Will the allowance require sit/stand/walk (even if only a few steps)?	YES☐	NO☐	

D. Please estimate the number of minutes and/or hours claimant is able to sit, stand, or walk ***at one time without interruption*** before needing to alternate or change positions:

Minutes/hours	<5	Up to 5min	Up to 10min	Up to 15min	Up to 20min	Up to 30min	Up to 45min	Up to 1 hour without a break	Up to 2 hours without a break
Sitting									
Walking									
Standing									

E. Please estimate the length of time needed before claimant can resume sitting, standing and walking

	<1 min	Up to 5 min	Up to 10 min	Up to 15 min	Other:
Sitting					Other:
Walking					Other:
Standing					Other:

LIE DOWN/RECLINE

Is there a reasonable medical probability that claimant will need to take lie down or recline from work activity during the workday to relieve or control the effects of the cardiac condition? ☐ Yes ☐ No ☐ Other:

If claimant needs to lie down or recline to relive or control the effects of the cardiac condition can you estimate for how *often* and for *how long* he or she may have to do so? About _____ minutes; every _____ hour(s)

UNSCHEDULED BREAKS

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

If claimant needs to take unscheduled breaks to relieve or control pain can you estimate how *often* and for how long he or she may have to do so? About _____ minutes; every _____ hour(s)

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: Interacting with the public, co-workers or supervisors. Meeting deadlines; working within a schedule; making decisions; exercising independent judgment; completing tasks; getting to work regularly. Maintaining necessary speed, precision and persistence and pace; complexity of the work and 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 four days per month
☐ About two days per month	☐ More than four days per month

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 _____