

RESIDUAL FUNCTIONAL CAPACITY WITHOUT INJURY TO UPPER EXTREMITY

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:					
Has any medication necessary to relieve and/or control pain and/or the underlying condition(s) been denied?								Yes <input type="checkbox"/>	No <input type="checkbox"/>				
If yes, has the claimant's functionality decreased as a result of the denied medication(s)?								Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Does claimant experience any side effects from the medication(s) that has not been denied?								Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Given the aforementioned and within a reasonable degree of medical probability please address the following questions:													
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 <input type="checkbox"/>	No <input type="checkbox"/>				
How many hours can claimant reasonably expect to sustain competitive work if vocationally and medically compatible work is identified? Hour(s) each day:					<1	1	2	3	4	5	6	7	8
Are assistive device(s) medically required and/or prescribed?								Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Arm Brace(s)	Back Brace	Walker	Cane	Wheel Chair	Scooter	Other:							
The claimant's dominant upper extremity is:						RIGHT <input type="checkbox"/>		LEFT <input type="checkbox"/>					

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 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd 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 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd 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 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd 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 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more
Climb Ladders					
Climb Stairs					
Balance					
Kneel					
Stoop					
Crouch					
Crawl					
Reaching: Over shoulders					
Reaching: Below shoulders					
Handling					
Fingering					
Feeling					

LOWER EXTREMITIES

The claimant's affected lower extremity is:			BOTH <input type="checkbox"/>	RIGHT <input type="checkbox"/>	LEFT <input type="checkbox"/>
FEET: Claimant can use FEET for <i>repetitive movements</i> , as in operating foot controls or driving.					
	Not at all	Rare 1-5% day	Occasionally up to 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more
Right					
Left					
Both					
With <i>prolonged sitting</i> should claimant leg(s) be elevated?				Yes <input type="checkbox"/>	No <input type="checkbox"/>

If elevating the leg(s) is required for any reason , how long should they be elevated?																	
Minutes/ hours	<5 min	5-10	11-15	16-20	21-30	31-45	1 hour	1 and ½ hour	Other:								
Right																	
Left																	
Both																	
Considering the response supra, please estimate how often the leg(s) should be elevated? Approximately every _____ minutes; and/or every: _____ hour(s)																	
If elevating the leg(s) is required for any reason , how high should they be elevated?																	
<input type="checkbox"/> 1-5inches	<input type="checkbox"/> Up to 10 inches	<input type="checkbox"/> Up to 15 inches		<input type="checkbox"/> Up to 20 inches		<input type="checkbox"/> Up to 25inches		<input type="checkbox"/> >25 inches									
<input type="checkbox"/> Below Knee	<input type="checkbox"/> Above Knee	<input type="checkbox"/> Waist Level		<input type="checkbox"/> Above Heart		<input type="checkbox"/> Other											
NECK/HEAD/CERVICAL REGION for repetitive actions such as: (check capacity for each activity)																	
	(# of hours in an 8-hour day)								Duration/Tolerance minutes								
	< 1	1	2	3	4	5	6	7	8	<5 min	5- 10	11- 15	16- 20	21- 30	31- 45	46- 60	Other
Physical Activity																	
Neck Flexion/ Extension																	
Neck Rotation																	
Claimant is restricted from activities involving: (check capacity for each activity)																	
				Restricted		Unrestricted		Comments									
Hazards (moving machinery, heights)																	
Driving Automotive Equipment																	
Exposure to Dust, Fumes, Gases																	
Changes in Temperature																	
Extreme heat																	
Extreme cold																	
Humidity																	
Wetness																	
Noise																	
Vibration																	

REASONABLE ACTIVITES TO CONTROL AND/OR RELIEVE PAIN

What is the most effective manner for claimant to control or manage his/her pain?		
<input type="checkbox"/> Take Medications	<input type="checkbox"/> Apply hot/cold packs	Other:
<input type="checkbox"/> Apply TENS Unit	<input type="checkbox"/> Alternate positions	
<input type="checkbox"/> Lie Down	<input type="checkbox"/> Avoid prolonged activities	
<input type="checkbox"/> Recline	<input type="checkbox"/> Use of supports	
<input type="checkbox"/> Rest	<input type="checkbox"/> Avoid offending activities	

Allowance to alternate positions:									
A. Will claimant need an allowance to alternate positions at will?						Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:	
B. Will the allowance to alternate positions include the ability to sit, stand, and walk even if only a few steps and /or stretch?						Yes <input type="checkbox"/>	No <input type="checkbox"/>		
C. 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									
D. 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 pain? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
If claimant needs to lie down or recline to relieve or control pain can you estimate for how <i>often</i> and for <i>how long</i> 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 during the workday? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?										
<table border="1"> <tr> <td>Not at all</td> <td>Rare 1-5% day</td> <td>Occasionally up to 1/3rd day</td> <td>Frequently 1/3rd to 2/3rd day</td> <td>Continuously 2/3rd day or more</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Not at all	Rare 1-5% day	Occasionally up to 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
How often during a typical workday will the combination of claimant's impairments interfere with an ability to perform sustained and competitive work ?										
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

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.	
<input type="checkbox"/> Incapable of "low stress" jobs	<input type="checkbox"/> Capable of low stress jobs
<input type="checkbox"/> Moderate stress is okay	<input type="checkbox"/> Capable of high stress work
Will claimant's impairments likely to produce " good days " and " bad days "? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	
<input type="checkbox"/> Never	<input type="checkbox"/> About three days per month
<input type="checkbox"/> About one day per month	<input type="checkbox"/> About four days per month
<input type="checkbox"/> About two days per month	<input type="checkbox"/> 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.

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

Signature of Physician _____ Date _____

Additional Comments: _____