

RESIDUAL FUNCTIONAL CAPACITY CERVICAL SPINE

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 <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)									<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 extremity is:									Right <input type="checkbox"/>				Left <input type="checkbox"/>				
NECK/HEAD/CERVICAL REGION (check capacity for each activity)																	
Physical Activity	(# of total hours in an 8-hour day)								Duration/Tolerance without a break								
	<1	1	2	3	4	5	6	7	8	<5 min	5-10	11-15	16-20	21-30	31-45	46-60	Other
Neck Flexion																	
Neck Extension																	
Neck Rotation																	
If episodes of pain exist, can they become minimum, slight, moderate, moderate to severe, or severe? Other:														Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Is it reasonable to expect cervical related pain, as described above, to increase at times spontaneously, unpredictably and/or without provocation?														Yes <input type="checkbox"/>		No <input type="checkbox"/>	
If yes, how often?																	
If spontaneous spikes in pain occur as described above, how long can they be expected to last out of an 8 hour work day or its equivalent: 5% of the day; 10% of the day; 15% of the day; 20% of the day; Other _____% of the day																	
CERVICOGENIC HEADACHES																	
Is there a medical probability that your patient's cervical condition will cause headaches?														Yes <input type="checkbox"/>		No <input type="checkbox"/>	
On average please characterize your patient's headaches in terms of intensity/severity; minimum, slight, moderate, moderate/severe, severe or other:																	
Identify any other symptoms associated with your patient's headaches:																	
Vertigo				Visual Disturbances													
Nausea/Vomiting				Mood Changes													
Malaise				Mental Confusion/Inability to Concentrate													
What is the average frequency of all headaches?									Approximate x's per day:								
									Approximate x's per week:								
What is the average duration of all headaches?									About _____ minutes; _____ hours								
What is the approximate frequency of severe headaches?									Approximate x's per day:								
									Approximate x's per week:								
What is the approximate duration of severe headaches?									About _____ minutes _____ hours								
During times your patient has a headache would your patient generally be precluded from performing even basic work activities and need a break from the workplace?														Yes <input type="checkbox"/>		No <input type="checkbox"/>	

UPPER EXTREMITY

Is there a medical probability that the cervical condition will cause problems with your patient's upper extremities?										Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which is the affected extremity:					Right <input type="checkbox"/>	Left <input type="checkbox"/>	Both <input type="checkbox"/>				
Identify any signs or symptoms your patient exhibits that affect shoulders, elbows, wrists, hands or fingers:											
<input type="checkbox"/> Tenderness			<input type="checkbox"/> Paresthesia			<input type="checkbox"/> Joint warmth					
<input type="checkbox"/> Pain			<input type="checkbox"/> Soft tissue swelling			<input type="checkbox"/> Joint deformity					
<input type="checkbox"/> Muscle spasm			<input type="checkbox"/> Muscle weakness			<input type="checkbox"/> Reduced grip strength					
<input type="checkbox"/> Redness			<input type="checkbox"/> Limitation of motion			<input type="checkbox"/> Muscle atrophy					
	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		
REACHING: Over shoulder(s)/head											
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	
REACHING: Below shoulder(s)											
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	
HANDLING: Seizing, holding, grasping, turning, or otherwise working with hand or hands. Fingers are involved only to the extent that they are an extension of the hand, such as to turn a switch or shift automobile gears.											
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	
FINGERING: Picking, pinching, or otherwise working primarily with fingers rather than with the whole hand or arm as in handling.											
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	

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										

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

	LIFT with RIGHT				
	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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
	LIFT with LEFT				
	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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					

Residual Functional Capacity

CARRY with RIGHT					
	Not at all	Rarely 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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
CARRY with LEFT					
	Not at all	Rarely 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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
PUSH/PULL					
	Not at all	Rarely 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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 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 Stairs					
Balance					
Stoop					
Crouch					

Claimant is restricted from activities involving: (check capacity for each activity)

	Restricted	Unrestricted	Comments
Hazards (moving machinery, heights)			
Driving Automotive Equipment			
Changes in Temperature			
Extreme heat			
Extreme cold			
Humidity			
Vibration			

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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <i>fatigue</i> due to the side effects from the medication?			Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Please list medications for non-industrial condition(s), if any?								
Is there a reasonable medical probability the claimant will experience side effects from <u>non-industrial medication(s)</u> , if any? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:								
Degrees of Functional Limitations defined: 1. None means no impairment is noted in the functions. 2. Mild implies that any discerned impairment is compatible with most useful functioning. 3. Moderate means that the identified impairments are compatible with some, but not all , useful functioning. 4. Marked is a level of impairment that significantly impedes useful functioning. Taken alone, a marked impairment would not completely preclude functioning, but together with marked limitation in another class, it might limit useful functioning. If appropriate, please choose <u>one</u> of the following definitions of “ off task ” for “ Moderate restriction ” you feel best describes your patient’s loss of useful function expressed as percentile: 1. <input type="checkbox"/> “Off task” 10% of the time over the course of an 8 hour day due to the side effects of medication; 2. <input type="checkbox"/> “Off task” 15% of the time over the course of an 8 hour day due to the side effects of medication; 3. <input type="checkbox"/> “Off task” 20% of the time over the course of an 8 hour day due to the side effects of medication; 4. <input type="checkbox"/> “Off task” ___% of the time over the course of an 8 hour day due to the side effects of medication; Assume that “off task” means an inability to perform the activity and/or a reduction in productivity over the course of an 8 hour work day.								
To what degree will the side effects impair claimant’s ability for concentration, persistence pace <u>separate and apart</u> from the underlying <u>industrial</u> medical condition(s)? <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Other:								
To what degree will the side effects impair claimant’s ability for concentration, persistence and pace in <u>combination</u> with the underlying <u>industrial</u> medical condition(s)? <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Other:								
When side effects exist can you estimate the severity? <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Other::								
	Hours	<1	2	3	4	5	6	Other:
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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> 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: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> 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: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Other:								
Is there a reasonable medical probability claimant’s <i>fatigue</i> , 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:								

REASONABLE ACTIVITIES 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 TENS Unit <input type="checkbox"/> Lie Down <input type="checkbox"/> Recline <input type="checkbox"/> Rest			<input type="checkbox"/> Apply hot/cold packs <input type="checkbox"/> Alternate positions <input type="checkbox"/> Avoid prolonged activities <input type="checkbox"/> Use of supports <input type="checkbox"/> Avoid offending activities			Other:			
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 <i>at one time without interruption</i> 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 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 relive 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 <i>often</i> 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 <i>attention and concentration</i> 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 of impairments interfere with an ability to perform <i>sustained and competitive work</i> ?										
<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"/>						
To what degree can claimant tolerate <i>work stress</i> 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.										

Residual Functional Capacity

<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: _____