RESIDUAL FUNCTIONAL CAPACITY DUE TO SKIN CONDITIONS

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:

2. Diagnoses:_____

3. Prognosis:_____

4. Identify symptoms your patient has had in the past year or continues to have:

☐ Skin lesions on multiple body sites
☐ Skin lesions that interfere with motion of
☐ one joint ☐ two or more joints
☐ Skin lesions on the palm(s) of
☐ one hand ☐ two hands
☐ Skin lesions on the sole(s) of
☐ one foot ☐ two feet
☐ Skin lesions affecting the perineum
☐ Loss of manual dexterity
☐ Chronic skin infections
☐ Skin fissures
☐ Skin ulcers
☐ Skin inflammation
☐ Swelling
☐ Skin weeping
☐ Skin bleeding
☐ Thick leathery skin
☐ Pain
☐ Skin lesions that interfere with use of
☐ one extremity ☐ two extremities
☐ Skin lesions affecting
☐ one ☐ both axillae
☐ Skin lesions affecting
☐ one ☐ both inguinal area(s)
☐ Difficulty walking
☐ Difficulty sitting
☐ Easily irritated skin
☐ Skin blisters
☐ Skin scaling
☐ Skin redness
☐ Skin crusting
☐ Skin cracking
☐ Hives
☐ Pruritis

Examples where claimant is likely to experience symptoms?			
☐ Head	☐ Fingers	☐ Knee(s)	
☐ Neck	☐ Upper Back	☐ Ankle (s)	Other:_____
☐ Shoulders	☐ Mid Back	☐ Foot	
☐ Arms	☐ Lower Back	☐ Chest	_____
☐ Wrists	☐ Buttocks	☐ Internal	
☐ Hands	☐ Leg(s)	☐ Groin	

5. If flare-ups occur please estimate the approximate frequency and duration:_____

_____

6. Describe skin lesions:_____

_____

7. Describe the treatment and response including any side effects of medication that may have implications for working, *e.g.*, drowsiness, dizziness, nausea, etc:

_____

8. Does your patient have extensive skin lesions that persist for at least 3 months despite continuing treatment as prescribed? ☐ Yes ☐ No

9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?
☐ Yes ☐ No

10. Identify any psychological conditions affecting your patient's physical condition:

☐ Depression	☐ Anxiety
☐ Somatoform disorder	☐ Personality disorder
☐ Psychological factors affecting physical condition	☐ Other: _____

11. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS	NO RESTRICTIONS	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
High humidity	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Dryness	☐	☐	☐	☐
Cigarette smoke	☐	☐	☐	☐
Perfumes	☐	☐	☐	☐
Cosmetics	☐	☐	☐	☐
Soldering fluxes	☐	☐	☐	☐
Solvents/cleaners	☐	☐	☐	☐
Fumes, odors, gases	☐	☐	☐	☐
Dust	☐	☐	☐	☐
Sand	☐	☐	☐	☐
Metals	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐
Glues	☐	☐	☐	☐
Wool	☐	☐	☐	☐
Rubber products	☐	☐	☐	☐
Synthetic fibers	☐	☐	☐	☐
Latex	☐	☐	☐	☐
Motor oils and/or grease	☐	☐	☐	☐
Working around food	☐	☐	☐	☐
Public contact	☐	☐	☐	☐
Co-worker contact	☐	☐	☐	☐
List other irritants:	☐	☐	☐	☐

_____

If foods are a known source causing symptoms please list: _____

If chemical are a known source causing symptoms please list: _____

When symptoms are present please assume the following degree of limitations:
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.
5. Extreme means that the impairment or limitation is not compatible with useful function.
Within a reasonable medical probability please evaluate claimant's capacity to perform the following functions over a normal workday and workweek, on an ongoing basis in the presence of acute or chronic symptoms:

When present your patient's symptoms can be expected to cause distractions for the following functions:	None	Mild	Moderate	Marked	Extreme
Maintain attention and concentration for extended periods.					
Maintain persistence and pace for extended periods.					
Perform activities within a set schedule; maintain regular attendance and punctuality within customary tolerances.					
Complete a normal workday and workweek without an unreasonable number of rest periods or interruptions due to pain.					
Maintain focus for activities such as reading, writing, and/or computer use or other activities requiring cognitive acuity without distraction due to pain.					

Please evaluate claimant's capacity to perform the following functions over a normal workday on an ongoing basis in the presence of his/her symptoms:

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

Please estimate claimants capacity to perform the following activities when symptoms are is present:

	Not at all		**Rare** 1-5% day		**Occasionally** up to 1/3rd day		**Frequently** 1/3rd to 2/3rd day		**Continuously** 2/3rd to 8 hrs.	
REACHING: **Over shoulder(s)/head** while extending hand(s) and arm(s).										
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left
REACHING: **Below shoulders** while extending hand(s) and arm(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
Simple Grasping										
Fine Manipulation										

How much is your patient likely to be ***"off task"***? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks? 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.

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

REASONABLE ACTIVITES TO CONTROL AND/OR RELIEVE SYMPTOMS

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

- Medication? Please list:_____
- Other:_____
- _____

When experiencing symptom(s):

A. Will claimant need an allowance to alternate positions?	YES☐	NO☐	Comments:
B. Will the allowance be restricted to sit/stand?	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 symptoms? ☐ Yes ☐ No ☐ Other:

If claimant needs to lie down or recline to relive or control pain 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 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 symptoms severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks as a result of the symptoms?

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 symptoms 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 symptoms and/or treatment?	
☐ Never ☐ About one day per month ☐ About two days per month	☐ About three days per month ☐ About four 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.

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

Signature of Physician _____ Date _____

Additional Comments:_____