URINARY AND FECAL INCONTINENCE

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

What type of **urinary** incontinence does your patient have, if any?

☐ Stress incontinence -- occurs during activities like coughing, sneezing, laughing, or exercise.

☐ Urge incontinence -- involves a strong, sudden need to urinate. The bladder squeezes and there is loss of urine. There is not enough time after the feeling of the need to urinate to get to the bathroom before urinating begins.

☐ Overflow incontinence -- occurs when the bladder cannot empty. This leads to dribbling.

☐ Mixed incontinence occurs when more than one type of urinary incontinence is present.

☐ Other:

Does your patient have urinary frequency?	Yes ☐ No ☐

If yes, please estimate approximately how often your patient must urinate: ___________________________________

a) please estimate approximately how often your patient is incontinent:_______________________________________

b) please estimate the volume of urine involved:____

What makes your patient's urinary frequency/ incontinence better?_______________________________________

What makes your patient's urinary frequency/ incontinence worse?_______________________________________

Are diapers and/or other protection medically required for urinary frequency/incontinence?	Yes ☐ No ☐
If yes please list:	
Approximately how often are diapers or other protection changed during an 8 hour day:	
Will your patient need to be close to a restroom?	Yes ☐ No ☐
If yes please estimate how close a restroom should be from the work station in feet?	Minutes?
Please estimate how often your patient will need to use the restroom? Every Minutes	Hour(s)

FECAL INCONTINENCE

Does your patient have **fecal** incontinence?	Yes ☐	No ☐
If yes, please estimate approximately how often your patient is incontinent:		
What makes your patient's fecal incontinence better?____ What makes your patient's fecal incontinence worse?____		
Are diapers and/or other protection medically required for fecal incontinence?	Yes ☐	No ☐
If yes please list:		
Approximately how often are diapers and/or other protection changed during an 8 hour day:		
Will your patient need to be close to a restroom?	Yes ☐	No ☐
If yes please estimate how close a restroom should be from the work station in feet? Minutes?		
Please estimate how often your patient will need to use the restroom? Every Minutes Hour(s)		
Has your patient reported soiling his or her clothing due to urinary and/or fecal leakage? ☐ Yes ☐ No		
Is it more likely than not that your patient will soil his or her clothing due to urinary and/or fecal leakage? ☐ Yes ☐ No Other:		
If yes, approximately how often during an average month will leakage occur resulting in needing a change of clothing?		
Do you recommend that your patient keep a change of clothing available when leaving home? ☐ Yes ☐ No		

Are any of the following symptoms associated with your patient's condition?

Chronic diarrhea	Anal fissures
Bloody diarrhea	Nausea
Abdominal pain and cramping	Peripheral arthritis
Fever	Kidney problems
Weight loss	Malaise
Loss of appetite	Fatigue
Bowel obstruction	Mucus in stool
Vomiting	Ineffective straining at stool (rectal tenesmus)
Abdominal distention	Sweatiness
Fistulas	Other:

Can accidental fecal leakage interfere with daily life?	Yes ☐	No ☐	Other:
If yes please explain?			

Will urinary or fecal incontinence result in avoidance from social activities for fear of embarrassment?	Yes ☐	No ☐
Will rectal urgency, frequency, and/or urinary incontinence increase with coughing and/or sneezing.	Yes ☐	No ☐

Can ***stress*** provoke or urinary or fecal incontinence?	Yes ☐	No ☐	Other:
To what degree can your patient tolerate ***work stress*** as a result of urinary and/or fecal incontinence:			
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

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/CARRY/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					

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 <u>one</u> of the 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 *<u>separate and apart</u>* from the underlying <u>industrial</u> 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 *<u>combination</u>* with the underlying <u>industrial</u> 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
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:

MEDICALLY REASONABLE ACTIVITES TO CONTROL SYMPTOMS

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? ☐ Yes ☐ No ☐ Other:

If yes can you estimate how *often* and for *how long* may he or she 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 due to urinary and/or fecal incontinence? ☐ Yes ☐ No ☐ Other:

If yes 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 symptoms from urinary and/or fecal incontinence that may 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 $1/3^{rd}$ day	**Frequently** $1/3^{rd}$ to $2/3^{rd}$ day	**Continuously** $2/3^{rd}$ day or more
☐	☐	☐	☐	☐

How often during a typical workday will urinary and/or fecal incontinence interfere with an ability to perform ***sustained and competitive work***?

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
☐	☐	☐	☐	☐

Will claimant have "good days" and "bad days"? ☐ Yes ☐ No ☐ Other:

Please estimate, on average, how many days per month claimant is likely to be absent from work as a result of the urinary and/or fecal incontinence and/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.

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

Signature of Physician ____________________________________ Date ______________________________

Additional Comments:____