RESIDUAL FUNCTIONAL CAPACITY 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:		
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 identified? Hour(s)	<1	1	2	3	4	5	6	7	8	
Are assistive device(s) medically required and/or prescribed?						YES ☐			NO ☐	
Arm Brace(s)	Back Brace	Walker	Cane	Wheel Chair	Scooter	Other:				
The claimant's dominant extremity is:						RIGHT ☐			LEFT ☐	
The claimant's affected extremity is:						RIGHT ☐			LEFT ☐	

Identify any signs or symptoms your patient exhibits that affect shoulders, elbows, wrists, hands or fingers:

☐ Tenderness	☐ Paresthesia	☐ Joint warmth
☐ Pain	☐ Soft tissue swelling	☐ Joint deformity
☐ Muscle spasm	☐ Muscle weakness	☐ Reduced grip strength
☐ Redness	☐ Limitation of motion	☐ Muscle atrophy
☐ Other		

	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
Estimate the amount of time in an 8-hour work day claimant can use hands/fingers/arms for the following activities:										
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left
Simple Grasping										
Fine Manipulation										
Repetitive activities										

Client can use HANDS for repetitive and competitive work for such activities as: (Estimate capacity for each activity)																	
	(# of hours in an 8-hour day)									Duration (# of continuous 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
Write																	
Keyboard																	
Mouse																	

NECK/HEAD/CERVICAL REGION for repetitive actions such as: (check capacity for each activity)																	
	(# of hours in an 8-hour day)									Duration/Tolerance							
Physical Activity	**<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/ Extension																	
Neck Rotation																	

FINE MANIPULATION

What degree of pain, if any, will claimant experience when performing ***competitive*** work requiring fine manipulation and/or fine dexterity with the affected upper extremity(ies)? ☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other:

GROSS MANIPULATION

What degree of pain, if any, will the claimant experiences when performing ***competitive*** work requiring gross manipulation with the affected upper extremity (ies)? ☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other:

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 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					
26-50 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					
26-50 pounds					

	CARRY 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					
26-50 pounds					
	CARRY 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					
26-50 pounds					
	PUSH/PULL				
	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					
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					
Balance					
Kneel					
Stoop					
Crouch					
Crawl					
Feeling					

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			
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)?
☐ 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:

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 one 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. ☐ "Off task" 10% of the time over the course of an 8 hour day due to the side effects of medication;
2. ☐ "Off task" 15% of the time over the course of an 8 hour day due to the side effects of medication;
3. ☐ "Off task" 20% of the time over the course of an 8 hour day due to the side effects of medication;
4. ☐ "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 *separate and apart* from the underlying industrial medical condition(s)?
☐ None ☐ Mild ☐ **Moderate** ☐ Marked ☐ 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)?
☐ None ☐ Mild ☐ **Moderate** ☐ Marked ☐ Other:

When side effects exist can you estimate the severity?
☐ None ☐ Mild ☐ **Moderate** ☐ Marked ☐ 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?
☐ 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: ☐ None ☐ Mild ☐ **Moderate** ☐ Marked ☐ 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: ☐ None ☐ Mild ☐ **Moderate** ☐ Marked ☐ 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: ☐ None ☐ Mild ☐ **Moderate** ☐ Marked ☐ 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 PAIN

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

Allowance to alternate positions:			
A. Will claimant need an allowance to alternate positions at will?	YES☐	NO☐	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☐	NO☐	

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? ☐ 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 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 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: 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 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.

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

Signature of Physician _____ Date _____

Additional Comments:_____