MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

Name:	
Claim #:	
Date of Injury:	

What is the first date at which your patient's impairment(s) became "severe" meaning that his or her impairment(s) caused interference their ADL's or ability to work?	Date:
When did you begin treating the patient?	Date:
How frequently do you see your patient?	Date:

In utilizing this form, please assume the following definitions:

Not Significantly Limited assumes an ability to perform the activity.

Markedly Limited assumes an inability to perform the activity.

If appropriate, please choose one of the following definitions of **"Moderately Limited"** you feel best describes your patient's impairments. Patient will be:

1. ☐ "Off task" 10% of the time over the course of an 8 hour day when performing the mental activity;
2. ☐ "Off task" 15% of the time over the course of an 8 hour day when performing the mental activity;
3. ☐ "Off task" 20% of the time over the course of an 8 hour day when performing the mental activity;
4. ☐ "Off task" 25% of the time over the course of an 8 hour day when performing the mental activity;
5. ☐ "Off task" ____% of the time over the course of an 8 hour day when performing the mental activity;

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.

A. UNDERSTANDING AND MEMORY	Not Significantly Limited	**Moderately Limited**	Markedly Limited	No Evidence of Limitation in this Category	Not Ratable on Available Evidence
1. The ability to remember locations and work-like procedures.	☐	☐	☐	☐	☐
2. The ability to understand and remember very short and simple instructions.	☐	☐	☐	☐	☐
3. The ability to understand and remember detailed instructions.	☐	☐	☐	☐	☐
B. SUSTAINED CONCENTRATION AND PERSISTENCE					
4. The ability to carry out very short and simple instructions.	☐	☐	☐	☐	☐
5. The ability to carry out detailed instructions.	☐	☐	☐	☐	☐
6. The ability to maintain attention and concentration for extended periods.	☐	☐	☐	☐	☐

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Ratable on Available Evidence
7. The ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances.	☐	☐	☐	☐	☐
8. The ability to sustain an ordinary routine without special supervision.	☐	☐	☐	☐	☐
9. The ability to work in coordination with or proximity to others without being distracted by them.	☐	☐	☐	☐	☐
10. The ability to make simple work-related decisions.	☐	☐	☐	☐	☐
11. The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	☐	☐	☐	☐	☐
C. SOCIAL INTERACTION					
12. The ability to interact appropriately with the general public.	☐	☐	☐	☐	☐
13. The ability to ask simple questions or request assistance.	☐	☐	☐	☐	☐
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	☐	☐	☐	☐	☐
15. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	☐	☐	☐	☐	☐
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	☐	☐	☐	☐	☐
D. ADAPTATION					
17. The ability to respond appropriately to changes in the work setting.	☐	☐	☐	☐	☐
18. The ability to be aware of normal hazards and take appropriate precautions.	☐	☐	☐	☐	☐

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Ratable on Available Evidence
19. The ability to travel in unfamiliar places or use public transportation.	☐	☐	☐	☐	☐
20. The ability to set realistic goals or make plans independently of others.	☐	☐	☐	☐	☐
As describe above, please provide the earliest date on which the residual functional capacities began to manifest?				Date:	

If stress tolerance is an issue, what demands of work does this patient find stressful?

☐	speed	☐	being criticized by supervisors
☐	precision	☐	simply knowing that work is supervised
☐	complexity	☐	getting to work regularly
☐	deadlines	☐	remaining at work for a full day
☐	working within a schedule	☐	fear of failure at work
☐	making decisions	☐	monotony of routine
☐	exercising independent judgment	☐	little latitude for decision-making
☐	completing tasks	☐	lack of collaboration on the job
☐	working with other people	☐	no opportunity for learning new things
☐	dealing with the public (strangers)	☐	underutilization of skills
☐	dealing with supervisors	☐	lack of meaningfulness of work

Has your patient's impairment lasted or can it be expected to last at least twelve months? ☐ Yes ☐ No

Are your patient's impairments reasonably consistent with the symptoms and functional limitations described in this evaluation? ☐ Yes ☐ No

If no, please explain:

Please describe any additional reasons not covered above why your patient would have difficulty working at a regular job on a sustained basis.

If your patient's impairments include alcohol or substance abuse, do alcohol or substance abuse contribute to any of your patient's limitations set forth above? ☐ Yes ☐ No

If Yes:

a) Please list the limitations affected:

b) Please explain what changes you would make to your description of your patient's limitations if your patient were totally abstinent from alcohol or substance abuse:

FUNCTIONAL CAPACITY ASSESSMENT

Please record in this section the elaborations on the preceding capacities. Include any information which clarifies limitation or function.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct 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: _____