PULMONARY
RESIDUAL FUNCTIONAL CAPACITY (RFC)

Name:	
Claim #:	
Date of Injury:	
Please Print Name of Medical Evaluator:	
Medical Specialty:	
What is the first date patient's impairment(s) became "severe" meaning that his/her impairment(s) caused interference ADL's or ability to work?	Date:
When did you begin treating the patient?	Date:
How frequently do you see your patient?	Date:

Have your patient's impairments lasted or can they be expected to last at least twelve months? ☐ Yes ☐ No

Prognosis: _____

Identify the clinical findings, laboratory and pulmonary function test results that show your patient's medical impairments:

_____

Identify all of your patient's ***symptoms***:

☐ Shortness of breath	☐ Rhonchi	☐ Episodic pneumonia
☐ Orthopnea	☐ Edema	☐ Fatigue
☐ Chest tightness	☐ Episodic acute asthma	☐ Palpitations
☐ Wheezing	☐ Episodic acute bronchitis	☐ Coughing

☐ Other symptoms: _____

If your patient has acute asthma attacks identify the precipitating factors:

☐ Upper respiratory infection	☐ Emotional upset/stress
☐ Allergens	☐ Irritants
☐ Exercise	☐ Cold air/change in weather
☐ Aspirin/tartazine	☐ Foods

Other_____

Characterize the nature and severity of your patient's attacks: _____

How often does your patient have asthma attacks? _____

How long is your patient incapacitated during an average attack? _____

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

If no, please explain: _____

Within a reasonable degree of medical probability:

Can the claimant reasonably be expected to sustain 8 hours of work a day?				YES☐				NO☐	
If no; how many hours can claimant reasonably be expected to work if vocationally and medically compatible work is indentified? Hour(s)	<1	1	2	3	4	5	6	7	8

SIDE EFFECTS FROM PRESCRIBED MEDICATION		
Is your patient taking prescribed medication for his/her medical condition(s):	YES☐	NO ☐
Please list **medications** for the industrial condition(s).	_____ _____ _____	

Is there a reasonable medical probability claimant will experience side effects from medication(s)?	YES☐	NO ☐

What other side effect(s) are likely, if any?

Sweating		Dry Mouth	
Fatigue		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	
Vomiting		Diarrhea	
Sedation		Weight Gain	

Other:

For the purpose of this RFC please assume that "off task" means an inability and/or a reduction in productivity over the course of an 8 hour work day. If appropriate, please choose <u>one</u> of the 3 following definitions of **"Moderate"** you feel best describes claimant's impairments..

1. ☐ Will be "off task" 10% of the time in an 8 hour day;
2. ☐ Will be "off task" 10%-25% of the time in an 8 hour day;
3. ☐ Will be "off task" 25% of the time in an 8 hour day;

"Mild" assumes an annoyance but no reduction to perform the function.
"Severe" assumes and inability to perform the function.

To what degree will the side effects impair claimant's ability for concentration, persistence pace *<u>separate and apart</u>* from the underlying 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 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	8
Approximate duration of the most severe side effect(s):								

Is claimant allowed to operate a motor vehicle or machinery when experiencing side effects from the medication?
☐ Yes ☐ No

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?
☐Yes ☐ No

EXERTIONAL PHYSICAL DEMANDS:
(INCLUDES: SIT, STAND, WALK, LIFT, CARRY, PUSH AND PULL)

How many hours of an 8-hour work day can claimant be expected to:

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

Will claimant need allowance to alternate positions at will?	YES☐	NO☐	Comments:

As a result of claimant's impairments, estimate the functional capacity for each activity if claimant were placed in a *competitive work situation.* Please estimate the number of minutes or hours claimant is able to sit, stand, or walk or drive ***<u>at one time</u>,*** before needing to alternate positions. Estimated maximum ***duration*** of activities:

Minutes/hours	<5 min	5	10	15	20	30	45	1 hour	2 hours	> 2 hours
Sitting										
Walking										
Standing										
Driving										

Will claimant need to take unscheduled breaks during an 8-hour workday?	YES ☐	NO ☐
If yes, how *often* do you estimate claimant may need to take unscheduled breaks?		

Duration of Breaks:
If claimant must take break(s) from sitting, walking, standing, or driving after the *maximum duration* can you estimate of the length of the break before claimant can return to *competitive* work?

Minutes/hours	<5 min	5	10	15	20	30	45	1 hour	Other:
Sitting									Other:
Walking									Other:
Standing									Other:
Driving									Other:

LYING DOWN		
In your opinion, is it advisable for claimant to lie down during the day to rest or relieve pain as a result of his or her medical condition(s)?	YES ☐	NO ☐
If yes, how often can claimant be expected to lie down to rest or relive pain during an 8 hour day?		

If claimant will need to lie down to rest or relive pain the estimated duration should be:

Minutes/hours	<5 min	5	10	15	20	30	45	1 hour	Other:
									Other:

EXERTIONAL PHYSICAL DEMANDS:
(INCLUDES: SIT, STAND, WALK, LIFT, CARRY, PUSH AND PULL)

Claimant is able to:					
	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
LIFT					
Up to 10 pounds					
11-20 pounds					
21-30 pounds					
CARRY					
Up to 10 pounds					
11-20 pounds					
21-30 pounds					
PUSH					
Up to 10 pounds					
11-20 pounds					
21-30 pounds					
PULL					
Up to 10 pounds					
11-20 pounds					
21-30 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					
Bend: Stoop					
Crouch					
Crawl					
Reaching					

Claimant is restricted from activities involving: (check capacity for each activity)			
	Restricted	Unrestricted	Comments
Driving Automotive Equipment			
Exposure to Dust, Fumes, Gases			
Changes in Temperature			
Extreme heat			
Extreme cold			
Humidity			
Wetness			
Cigarette smoke			
Perfumes			
Soldering fluxes			
Solvents/cleaners			
Other:			

How often during a typical workday will the combination of claimant's of 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 ☐	YES ☐

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

FATIGUE

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
☐	☐	☐	☐	☐

Assume that "off task" means an inability to perform the activity. If appropriate, please choose <u>one</u> of the 3 following definitions of **"Moderate"** you feel best describes your patients impairments ***<u>due to fatigue</u>***.

1. ☐ Will be "off task" 10% of the time in an 8 hour day;
2. ☐ Will be "off task" 10%-25% of the time in an 8 hour day;
3. ☐ Will be "off task" 25% of the time in an 8 hour day;

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category
Ability to perform tasks that require constant concentration, such as driving a vehicle to and from work.	☐	☐	☐	☐

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category
Ability to perform tasks that require constant concentration, such as operating machinery, equipment or electric operated tools.	☐	☐	☐	☐
Ability to maintain concentration and attention for extended periods (the approximately 2-hour segments between arrival and first break, lunch, second break, and departure).	☐	☐	☐	☐
Ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	☐	☐	☐	☐
Ability to sustain an ordinary routine over an eight hour work day.	☐	☐	☐	☐
Ability to be aware of normal hazards and take appropriate precautions.	☐	☐	☐	☐
Ability to maintain attention for extended periods of 2-hour segments (concentration is not critical).	☐	☐	☐	☐
Ability to maintain regular attendance and be punctual within customary tolerances.	☐	☐	☐	☐
Ability to complete a normal workday and workweek without interruptions from *fatigue* and perform at a consistent pace without an unreasonable number and length of rest periods.	☐	☐	☐	☐

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.

Signature of Physician_____Date _____