VERTIGO RESIDUAL FUNCTIONAL CAPACITY

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:	

1. Does your patient experience dizziness? __ Yes __ No

2. If yes, what diagnosis is this dizziness related to? _____

_____

3. What is the average frequency of your patient's dizziness episodes?

_____ per week _____ per month

4. How long does a typical episode last? _____

5. Does your patient always have a warning of impending dizziness? __ Yes __ No

If yes, how long is it between the warning and the onset of the dizziness? _____minutes

6. Can your patient always take safety precautions when he/she feels an episode coming on?
__ Yes __ No

7. Does dizziness occur at a particular time of the day? __ Yes __ No

If yes, explain when dizziness occurs: _____

8. Are there precipitating factors such as stress, exertion? __ Yes __ No

If yes, explain:_____

9. Identify symptoms associated with your patient's dizziness episodes?

__ Nausea/vomiting
__ Visual disturbances
__ Malaise
__ Mood changes
__ Photosensitivity
__ Mental confusion/inability to concentrate
__ Sensitivity to noise
__ Fatigue/exhaustion
__ Hot flashes
__ Falling

__ Other: _____

10. After the episode ends, are there any after effects? *Check those that apply:*

__ Confusion
__ Exhaustion
__ Irritability
__ Other: _____
__ Severe headache
__ Muscle strain
__ Paranoia

11. How long after an episode do these after effects last? _____

12. Describe the degree to which dizziness episodes interfere with your patient's daily activities:

_____

13. Does your patient have a history of injury during an episode? __ Yes __ No

14. Type of medication and response: _____

15. Will your patient need more supervision at work than an unimpaired worker? __ Yes __ No

16. Can your patient work at heights? __ Yes __ No

17. Can your patient work with power machines that require an alert operator? __ Yes __ No

18. Can your patient operate a motor vehicle? __ Yes __ No

19. Can your patient take a bus alone? __ Yes __ No

20. Does your patient have any associated mental problems? *Check those that apply:*

__ Depression
__ Irritability
__ Social isolation
__ Poor self-esteem
__ Short attention span
__ Memory problems
__ Behavior extremes
__ Other: _____

21. Will your patient sometimes need to take unscheduled breaks during an 8-hour working day? __Yes __No

If yes, 1) how *often* do you think this will happen? _____
2) how long (on average) will your patient have to rest before returning to work? _____

22. To what degree can your patient tolerate work stress?

__ Incapable of even "low stress" jobs
__ Moderate stress is okay
__ Capable of low stress jobs
__ Capable of high stress work

Please explain the reasons for your conclusion: _____

23. Are your patient's impairments likely to produce "good days" and "bad days"? __ Yes __ No

If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments 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

24. Please describe any other limitations (such as limitations in the ability to sit, stand, walk, lift, bend, stoop, limitations in using arms, hands, fingers, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

25. Identify any additional tests or procedures you would advise to fully assess your patient's impairments, symptoms and limitations:

_____

Please consider the following functions within the context of your patient's capacity to sustain the activity over a normal workday and workweek, on an ongoing basis. If appropriate and by analogy, utilize degrees of functional loss classified in chapter 14.3e "Class of Impairments Due to Mental and Behavioral Disorders:"

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.
5. Extreme means that the impairment or limitation is not compatible with useful function.

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 vertigo;
2. ☐ "Off task" 15% of the time over the course of an 8 hour day due to vertigo;
3. ☐ "Off task" 20% of the time over the course of an 8 hour day due to vertigo;
4. ☐ "Off task" 25% of the time over the course of an 8 hour day due to vertigo;
5. ☐ "Off task" ____% of the time over the course of an 8 hour day due vertigo;

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	None	Mild	Moderate	Marked	Extreme
The ability to remember locations and work-like procedures.	☐	☐	☐	☐	☐
The ability to understand and remember very short and simple instructions.	☐	☐	☐	☐	☐

	None	Mild	Moderate	Marked	Extreme

The ability to understand and remember detailed instructions.	☐	☐	☐	☐	☐
B. SUSTAINED CONCENTRATION & PERSISTENCE					
Carry out very short and simple instructions.	☐	☐	☐	☐	☐
Carry out detailed instructions.	☐	☐	☐	☐	☐
Maintain attention and concentration for extended periods.	☐	☐	☐	☐	☐
The ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances.	☐	☐	☐	☐	☐
The ability to sustain an ordinary routine without special supervision.	☐	☐	☐	☐	☐
The ability to work in coordination with or proximity to others without being distracted by them.	☐	☐	☐	☐	☐
The ability to make simple work-related decisions.	☐	☐	☐	☐	☐
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					
The ability to interact appropriately with the general public.	☐	☐	☐	☐	☐
The ability to ask simple questions or request assistance.	☐	☐	☐	☐	☐
The ability to accept instructions and respond appropriately to criticism from supervisors.	☐	☐	☐	☐	☐
The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	☐	☐	☐	☐	☐
The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	☐	☐	☐	☐	☐
D. ADAPTATION					
The ability to respond appropriately to changes in the work setting.	☐	☐	☐	☐	☐
The ability to be aware of normal hazards and take appropriate precautions.	☐	☐	☐	☐	☐
The ability to travel in unfamiliar places or use public transportation.	☐	☐	☐	☐	☐
The ability to set realistic goals or make plans independently of others.	☐	☐	☐	☐	☐

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:_____