

RESIDUAL FUNCTIONAL CAPACITY DUE TO PAIN

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:
Has any medication necessary to relieve and/or control pain and/or the underlying condition(s) been denied?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, has the claimant's functionality decreased as a result of the denied medication(s)?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Does claimant experience any side effects from the medication(s) that has not been denied?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Given the aforementioned and within a reasonable degree of medical probability please address the following questions:			
Is there a reasonable medical probability that claimant's underlying condition will generate a pain response?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Can you please list the medical condition(s) and objective findings through diagnostic test, if any, that can reasonably be expected to generate pain:			
If yes, is there a medical probability that claimant will:			Yes <input type="checkbox"/> No <input type="checkbox"/>
a. Experience "referred" pain to other body parts?			Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Experience "deferred" pain after engaging in physical activities?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Examples where claimant is likely to experience pain?			
<input type="checkbox"/> Head	<input type="checkbox"/> Fingers	<input type="checkbox"/> Knee(s)	Other:
<input type="checkbox"/> Neck	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Ankle (s)	
<input type="checkbox"/> Shoulders	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Foot	
<input type="checkbox"/> Arms	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Chest	
<input type="checkbox"/> Wrists	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Internal	
<input type="checkbox"/> Hands	<input type="checkbox"/> Leg(s)	<input type="checkbox"/> Groin	
Please describe the quality of claimant's pain:			
<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Tingling	Other:
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Stinging	<input type="checkbox"/> Acute	
<input type="checkbox"/> Shooting	<input type="checkbox"/> Cramping	<input type="checkbox"/> Chronic	
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Radiating	<input type="checkbox"/> Numbness	
<input type="checkbox"/> Pinching	<input type="checkbox"/> Aching	<input type="checkbox"/> Burning	
Will changes in temperature, exposure to cold, humidity or wetness associated with claimant's impairments generate a pain response? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:			
Will pain, depending on the frequency, duration and intensity result in functional limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:			
In utilizing this form, please assume the following definitions of " <u>degree of limitations</u> :" [Chapter 14.3e of the AMA Guides]			
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.

Within a reasonable medical probability please evaluate claimant's capacity to perform the following functions over a normal workday and workweek, on an ongoing basis in the presence of chronic, acute and/or variable pain:

Pain can be expected to cause distractions for the following functions:	None	Mild	Moderate	Marked	Extreme
Carry out short and simple instruction.					
Carry out detailed instructions.					
Maintain attention and concentration for extended periods.					
Maintain persistence and pace for extended periods.					
Perform activities within a set schedule; maintain regular attendance and punctuality within customary tolerances.					
Complete a normal workday and workweek without an unreasonable number of rest periods or interruptions due to pain.					
Maintain focus for activities such as reading, writing, and/or computer use or other activities requiring cognitive acuity without distraction due to pain.					
Can episodes of pain become <i>moderate, moderate to severe, or severe</i> ? [Circle one or more]				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other:					
Is it reasonable to expect claimant's pain, as described above, to increase at times spontaneously, unpredictably and/or without provocation?				Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes, how often?

If spontaneous spikes in pain occur as described above, how long can they be expected to last out of an 8 hour work day or its equivalent: 5% of the day; 10% of the day; 15% of the day, 20% of the day; Other _____ % of the day

Please evaluate claimant's capacity to perform the following functions over a normal workday on an ongoing basis in the presence of **chronic, acute and/or persistent pain**:

Hours	<1	1	2	3	4	5	6	7	8
Sit									
Stand									
Walk									
	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
Climb Stairs									
Balance									
Stoop									
Crouch									
Crawl									

UPPER EXTREMITIES

The claimant's dominant extremity is:	RIGHT <input type="checkbox"/>	LEFT <input type="checkbox"/>
The claimant's affected extremity is:	RIGHT <input type="checkbox"/>	LEFT <input type="checkbox"/>

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

<input type="checkbox"/> Tenderness	<input type="checkbox"/> Paresthesia	<input type="checkbox"/> Joint warmth
<input type="checkbox"/> Pain	<input type="checkbox"/> Soft tissue swelling	<input type="checkbox"/> Joint deformity
<input type="checkbox"/> Muscle spasm	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Reduced grip strength

<input type="checkbox"/> Redness			<input type="checkbox"/> Limitation of motion			<input type="checkbox"/> Muscle atrophy				
Please estimate claimants capacity to perform the following activities:										
	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 while extending hand(s) and arm(s).										
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left
REACHING: Below shoulders while extending hand(s) and arm(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 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										
If one upper extremity is affected will claimant likely use the uninjured extremity to guard, assist, and massage or rub the injured extremity to relieve pain and discomfort?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Other:	

LOWER EXTREMITY IMPAIRMENTS:

With <i>prolonged sitting</i> should claimant leg(s) be elevated to avoid reduce pain?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Other:	
If yes, can you estimate how <i>often</i> he/she may need to elevate the leg(s)?							<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	
About _____ minutes; every _____ hour(s)										
If elevation of the leg(s) is required, how <i>long</i> will the leg(s) require elevation at one time?										
Minutes/ hours	<5min	5-10	11-15	16-20	21-30	31-45	1 hour	1 ½ hour	Other:	
Right										
Left										
Both										
<input type="checkbox"/> 1-5 inches	<input type="checkbox"/> Up to 10"		<input type="checkbox"/> Up to 15"		<input type="checkbox"/> Up to 20"		<input type="checkbox"/> Up to 25"		<input type="checkbox"/> >25 inches	
<input type="checkbox"/> Below Knee	<input type="checkbox"/> Above Knee	<input type="checkbox"/> Waist Level	<input type="checkbox"/> Above Heart	<input type="checkbox"/> Other						

REASONABLE ACTIVITIES TO CONTROL AND/OR RELIEVE PAIN

What is the most effective manner for claimant to control or manage his/her pain?

<input type="checkbox"/> Take Medications	<input type="checkbox"/> Apply hot/cold packs	Other:
<input type="checkbox"/> Apply TENS Unit	<input type="checkbox"/> Alternate positions	
<input type="checkbox"/> Lie Down	<input type="checkbox"/> Avoid prolonged activities	
<input type="checkbox"/> Recline	<input type="checkbox"/> Use of supports	
<input type="checkbox"/> Rest	<input type="checkbox"/> Avoid offending activities	

Allowance to alternate positions:

A. Will claimant need an allowance to alternate positions at will?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	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 <input type="checkbox"/>	No <input type="checkbox"/>							
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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
If claimant needs to lie down or recline to relive or control pain can you estimate for how <i>often</i> and for <i>how long</i> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:				
If claimant needs to take unscheduled breaks to relieve or control pain can you estimate how <i>often</i> 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 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often during a typical workday will the combination of claimant's of impairments interfere with an ability to perform <i>sustained and competitive work</i> ?				
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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To what degree can claimant tolerate <i>work stress</i> 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.				
<input type="checkbox"/> Incapable of "low stress" jobs		<input type="checkbox"/> Capable of low stress jobs		
<input type="checkbox"/> Moderate stress is okay		<input type="checkbox"/> Capable of high stress work		
Will claimant's impairments likely to produce "good days" and "bad days"? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?				
<input type="checkbox"/> Never		<input type="checkbox"/> About three days per month		
<input type="checkbox"/> About one day per month		<input type="checkbox"/> About four days per month		
<input type="checkbox"/> About two days per month		<input type="checkbox"/> 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: _____